DEPT.- 65

JOB- 21

REEL- 52

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

WP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B.	C.
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C. P. Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Bks.

D 88271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 88271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged men + women Home ST., WARD)

2-FULL NAME Mary Mason

(a) RESIDENCE NO. 822 S. Kirk ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate at

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Jones

(Address) 1622 Hanover Ave

Filed JUL 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1923 to June 29, 1924

that I last saw h alive on June 29, 1924

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley M. D.

6/30 1924 (Address) 1220 Saint Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 7/1 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Uhler St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88272

CERTIFICATE OF DEATH.

31 D 88272

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 Altona ave St., Hamilton 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Toal

(a) Residence No. 112 Altona ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Toal

6-DATE OF BIRTH (month, day and year) June 19-1864

7-AGE, 60 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, John Toal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Moran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Mary Toal

(Address) 112 Altona ave

15- JUL 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 28-1924

17- I HEREBY CERTIFY, That I attended deceased from June 21 1924 to June 28 1924

that I last saw him alive on June 24 1924

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 1 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D

6/30, 1924 (Address) Hamilton Balto Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. H of B Redemption — DATE OF BURIAL. July 1 1924

20-UNDERTAKER J. A. Moran — ADDRESS 300 E Balto.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88273

CERTIFICATE OF DEATH.

96

D 88273

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2605 Hampden Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Fannie Kholhepp

(a) Residence No. 2605 Hampden Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Kholhepp

6-DATE OF BIRTH (month, day and year) Oct 2 1857

7-AGE, 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) George Kholhepp

(Address) 2605 Hampden Ave

15- JUL 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 24 19 24 to June 29 19 24

that I last saw her alive on June 29 19 24

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Heart block

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H E Jones M. D

6/30 19 24 (Address) 720 N North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: July 2 19 24

20-UNDERTAKER. — ADDRESS: GRENOWETH & SON, [illegible] CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Mrs Allen.

D 83274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83274

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 W. Saratoga St ST., 18 WARD)

2-FULL NAME Mrs Allen

(a) RESIDENCE No. 837 W Saratoga St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	38	—	—	

8 OCCUPATION OF DEACEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Ella Allen
(Address) 837 W Saratoga

15 Filed JUL 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) M K Gwinn, M. D.
(Coroner.)

6/30, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/1/24
20 UNDERTAKER David Easton	ADDRESS 916 Penn

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88275 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary. REGISTERED NO. 15 49

CITY OF BALTIMORE: (No. North Broadway ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nellie V. Hudgins.

(a) RESIDENCE No. 3313 Walbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of J. R. Hudgins.

6 DATE OF BIRTH (month, day, and year) Jan. 9 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	62	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Emerson Rokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Adana Newbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant John R. Hudgins

(Address) 3313 Walbrook ave.

15 Filed JUL 1 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to June 29, 1924,

that I last saw her alive on June 29, 1924

and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatous ulcer of left thigh with general metastases.

(duration) yrs. 10? mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of 5-14-24

Was there an autopsy?

What test confirmed diagnosis? Microscopic Section.

(Signed) Henry U. P. Wood Jr. M.D. M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	July 1 1924
20 UNDERTAKER	ADDRESS
Wm. E. Black	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88276

1-PLACE OF DEATH

City of BALTIMORE: (No. 2923 Winchester St St., 16 Ward) 57 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Enroe

(a) Residence No. 2923 Winchester St St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Walter C Enroe

6-DATE OF BIRTH (month, day and year) June 5 1864

7-AGE, 60 yrs. mos. 24 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS:
10-NAME OF FATHER, William J Fergusson
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Richmond Va
12-MAIDEN NAME OF MOTHER, Mary Fox
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Richmond Va

14- (Informant) Elsie R Wells
(Address) 2923 Winchester St

15- Filed 192 ROBERT R. KRAUTER, Registrar.
JUL 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to June 29 19 24
that I last saw her alive on June 28 19 24
and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Septic Infection from Gangrene of right Leg

(Duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus & Chronic Nephritis

(Duration) 6 yrs mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 9 1924

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Harleman M. D.

, 19 (Address) 330 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL, July 1 1924

20-UNDERTAKER, Harry N Amacost — ADDRESS 4204 Ridgewood Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88277 HEALTH DEPARTMENT—CITY OF BALTIMORE

1001
100 D 88277

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 W. Lexington ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas Edw Hughes -

(a) RESIDENCE NO. 923 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	1	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Walter Hughes

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mackall

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Dr Thos Mackall
(Address) 923 W. Lexington

15 Filed JUL 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~his~~ death ~~(Inquest, autopsy or inquiry.)~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Gorsuch, M. D.
(Coroner.)

July 1 - 192 4 (Address) 1717 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Clare Cem DATE OF BURIAL July 192 4

20 UNDERTAKER Samuel Wesley ADDRESS Brad

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 88278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 88278

CITY OF BALTIMORE: (No. Municipal Hospital ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Brown

(a) RESIDENCE. NO. Bay View Asylum ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

JUL 1 - 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-11, 1924 to 6-26, 1924 that I last saw him alive on 6-25, 1924 and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Bruce M. D

6-28 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND. 19

20 UNDERTAKER — ADDRESS

(per Commissioner Health.) JUL 1 - 192

FOR WM. S. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

204

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-601

D 88279

CERTIFICATE OF DEATH.

D 88279

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 164 N. Potomac ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Raulston Jackson, Jr.

(a) RESIDENCE. NO. 164 N. Potomac ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				5 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Earl Raulston Jackson

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rehmer

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Dr. P. Artigiani
(Address)

15 Filed . 19 Registrar

JUL 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30/, 19 24, to June 30/, 19 24, that I last saw h[illegible] alive on June 30/, 19 24, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Rehrer State Board	19
20 UNDERTAKER	ADDRESS
[illegible] Commissioner of Health.	JUL 1 1924

Spec—12-23-21—E.B.K.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88280

CERTIFICATE OF DEATH.

100 D 88280

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 S. Linwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Howard Bohlager

(a) Residence No. 815 S. Linwood Ave St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 28-1923

7-AGE. 1 yrs. 3 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (City or town)..... Balto.
(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER, Alphonsus J. Bohlager

11-BIRTHPLACE OF FATHER (city or town)..... Balto.
(State or Country)..... Md.

12-MAIDEN NAME OF MOTHER, Mary C. Murphy

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country)..... Md.

14-(Informant)..... Mary C. Bohlager
(Address)..... 815 S. Linwood Ave.

JUL 1 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 29-1924

17 I HEREBY CERTIFY, That I attended deceased from June 26 1924 to June 28 1924
that I last saw h. alive on June 28 1924
and that death occurred, on the date stated above, at 4.00 a.m.
The CAUSE OF DEATH* was as follows: Dentition +
Capillary Bronchitis

(Duration)..... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(Duration)..... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis?.....

(Signed) M J McAvoy M. D
June 29 1924 (Address) 839 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cem.	July 1 1924
20-UNDERTAKER. Lilly & Zeller	ADDRESS 1038 N. Howard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88281

CERTIFICATE OF DEATH.

D 88281

Registered No. 74

1-PLACE OF DEATH

City of BALTIMORE: (No. 3116 Foster ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Tiehlbaum

(a) Residence No. 3116 Foster ave St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/r yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Late George Tiehlbaum

6-DATE OF BIRTH (month, day and year): Feb 24 1842

7-AGE: 82 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Ebert

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs George J. Benzing

(Address): 3116 Foster Ave

15- Filed ... 192... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

JUL 1 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to June 28 1924

that I last saw her alive on June 27 1924

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

A Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H McElroy M. D

June 29 192 (Address) 839 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem

DATE OF BURIAL: July 2nd 1924

20-UNDERTAKER: Lilly Zeiler

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88282

D 88282

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Tivoli Ave. ST.: 9 WARD)

2-FULL NAME Valentine Goeb

(a) RESIDENCE. NO. 2727 Tivoli ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline E. Goeb.

6 DATE OF BIRTH (month, day, and year) Jan. 21 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Goeb

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Winter

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Caroline E. Goeb.
(Address) 2727 Tivoli Ave.

JUL 1 - 1924 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to June 29, 1924, that I last saw him alive on June 29, 1924, and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency and Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Chas R. Wisang, M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 1 1924
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Wolfe St.

READING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificates.

Rec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 ✓ D 88283

D 88283

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 S. Robinson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shamer

(a) RESIDENCE. NO. 507 S. Robinson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 30, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 20 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER William Shamer

11 BIRTHPLACE OF FATHER (city or town) Etapsco
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Myers.

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant William Schamer.
(Address) 507 S. Robinson St

15 Filed JUL 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to June 30, 1924, that I last saw her alive on June 30, 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.
Congenital
Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Prematurity.
7th month. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) James G. Marston, M. D.
6-30 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 1 1924
20 UNDERTAKER Lilly & Zeller	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88284

D 88284

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 C Preston St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M Wier

(a) Residence No. 3515 Fairview ave St., Ward New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 7-1888

7-AGE, 35 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Clifton New York

PARENTS.

10-NAME OF FATHER, Alanson B La Sure

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Clifton N Y

12-MAIDEN NAME OF MOTHER, Mary Saunderlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Richmond Va

14- (Informant) Harold B Wier

(Address) 3515 Fairview Ave

15- JUL 1 - 1924 ROBERT A. KRANTZ Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1924, to June 30 1924, that I last saw h[er] alive on June 30 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

Endocarditis & Nephritis Chr

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis & Chr Nephritis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Sebastian M. D.

7/1, 1924 (Address) 2806 Fairview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Clifton New York — DATE OF BURIAL, 7/1/24, 19....

20-UNDERTAKER, George J Smith — ADDRESS 1532 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88285

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Oak St. 12 WARD)

2-FULL NAME Clara Knight

(a) RESIDENCE NO. 910 Jordan Alley ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Thumbland Co. Va

PARENTS

10 NAME OF FATHER: John Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Thumbland Co Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Martha Skinner
(Address): 2015 Oak St

15 Filed JUL 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular disease of heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison, M. D.
(Coroner.)

June 30 1924 (Address) 3C S. Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 1st 192
20 UNDERTAKER: Joseph A Ward	ADDRESS 2319 Division St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88286

CERTIFICATE OF DEATH.

74-001

74 D 88286

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Roland Ave & Ebendale Rd ST., 27 WARD)

2-FULL NAME Emma Heldmann Weber

(a) RESIDENCE No. Roland Ave & Ebendale Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: August Weber

6 DATE OF BIRTH (month, day, and year): February 21 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joel Heldmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Van Kolch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Weber

(Address) Roland & Ebendale Rd

JUL 1 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6 1924, to June 30, 1924.

that I last saw her alive on June 30, 1924;

and that death occurred, on the date stated above, at 1 15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteris-Sclerosis, Hypertension, Myocarditis (duration) 2 yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedmann, M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 2nd 1924
20 UNDERTAKER	ADDRESS
Henry H Jenkins Sons Co.	Edmondson Ave & Collins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 515 Brice ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Concannon.

(a) RESIDENCE. No. 515 Brice ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Concannon

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Augustin Concannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sarah Concannon. (Address) 515 Brice St.

15 Filed JUL 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1924. to June 29 1924.

that I last saw him alive on June 28, 1924.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) J. J. Hennessy, M. D.

(Address) 2 E Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Govans	July 2 1924

20 UNDERTAKER E. A. Wiedefeld Jr ADDRESS 501 E 22

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88288

CERTIFICATE OF DEATH.

90 D 88288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Arold (Arolds)

(a) RESIDENCE NO. 1400 Central Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Arold

6 DATE OF BIRTH (month, day, and year) Oct 2-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer Dr Brady

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Arold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Arold

(Address) Lutherville Balto Co Md

15 Filed JUL 1 -1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/24 19

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to July 1, 1924, that I last saw him alive on July 1, 1924, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of No

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Sybert, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 3rd 1924

20 UNDERTAKER W B Cook Co

ADDRESS 502 E Monument

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88289

D 88289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4016 Bonner Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Blackwell Glazebrook

(a) Residence No. 4016 Bonner Road St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lennie C

6-DATE OF BIRTH (month, day and year) Jan 25 1856

7-AGE. 68 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Pa

PARENTS.

10-NAME OF FATHER. John Glazebrook

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Jane Kuen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

14- (Informant) Lily da Glazebrook

(Address) 1 W Eutaw St

15- Filed JUL 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 30 1924

17- I HEREBY CERTIFY, That I attended deceased from June 27 1924 to June 30 1924

that I last saw h[illegible]live on June 30 1924

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cardia

+ Oesophagus end of

Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

from metastasis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stenosis of Oesophagus

(Signed) A. C. Schmuck M. D

July 5th 1924 (Address) 4309 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 2 1924

20-UNDERTAKER Wm Cook — ADDRESS 500 E Wash.

CK 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88290

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. ST., 15 WARD)

2-FULL NAME Phillip E. Shock

(a) RESIDENCE No. 1714 N. Calhoun St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice B. Shock

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Upholsterer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self.

9 BIRTHPLACE (city or town) .....
(State or country) Penna.

PARENTS

10 NAME OF FATHER Samuel F. Shock

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Hess

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Harry L. Shock
(Address) 114 Gibbon Ave. Catonsville, Md.

15 Filed ....., 192.... Robert F. Harrison, Registrar

JUL 1 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. T. Hennessy M. D.
(Coroner.)

June 30, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	7/2/24
20 UNDERTAKER Geo. Weber & Son	ADDRESS 2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88291

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 88291

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Loyal St. 4 WARD)

2-FULL NAME Baby Parrott

(a) RESIDENCE NO. 207 Loyal St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6/22/24

7 AGE: Years ... Months ... Days: 9 ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Henry Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Mary Parrott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mother

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar: Robert P. Harrison, Permit Clerk

JUL 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22. 1924, to June 30. 1924, that I last saw h[illegible] alive on June 30. 1924, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Thomas Lee, M. D.

7/1, 1924 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 1 - 1924

20 UNDERTAKER: Commissioner Health,

ADDRESS

Per Wm. P. WOODALE.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2900 Walbrook Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edward C Bartling

(a) Residence No. 2900 Walbrook Avenue St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 41 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Bartling

6-DATE OF BIRTH (month, day and year) Mar. 17, 1859

7-AGE, 65 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mr. Bartling

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Johanna Bartling

(Address) 2900 Walbrook Avenue

15- Filed ..... 192 ..... Registrar.

JUL 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 14 2, 19 24, to June 29, 19 24, that I last saw him alive on June 28, 19 24, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

Grippe & Bronchitis followed by Endocarditis. Cardiac Decompensation

(Duration) ..... yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Chas H Bullock, M. D.

6-30-1924 (Address) 1100 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	July 2nd, 19 24
20-UNDERTAKER.	**ADDRESS**
Jos B Cook	1003 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Stevenson).

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88293

CERTIFICATE OF DEATH.

117 D 88293

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Edison Stenson

(a) RESIDENCE NO. 3504 Calloway Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. F. E. Stenson

6 DATE OF BIRTH (month, day, and year) Jan 10 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Treas Md. Biscuit Co

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Jas. F. Stenson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hearne

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Willard Stevenson
(Address) Pocomoke City Md

15 Filed JUL 1 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-1924

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1924, to July 1, 1924,
that I last saw h(im) alive on July 1, 1924,
and that death occurred, on the date stated above, at 12.05 p m.
The CAUSE OF DEATH* was as follows:

Appendix Abscess (7)

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
Peritonitis (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 27th

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) J.F. King, M. D.

, 19 (Address) Pocomoke City Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pocomoke City Md	July 3 1924
UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 1 1924

Spec.—1-10-21—M&T—1500 Blks.

D 88294 HEALTH DEPARTMENT—CITY OF BALTIMORE 09 D 88294

CERTIFICATE OF DEATH. 111-09

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gorgas Rittenhouse

(a) RESIDENCE NO. Germantown, Pa. ST., WARD Germantown Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nicholas M. Rittenhouse

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER John Rittenhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Penna.

12 MAIDEN NAME OF MOTHER Mary Lyndon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Mrs. David F. Young

(Address) 39 Carpenter Lane Germantown Pa.

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to July 1, 1924, that I last saw her alive on July 1, 1924, and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

General Peritonitis

(duration) ~~Unknown~~ yrs. mos 2 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 30, 1924

Was there an autopsy? No Yes + Operation

What test confirmed diagnosis? Physical examination

(Signed) J. Ogle Warfield, Jr. M. D.

7/1, 1924 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Park Cem DATE OF BURIAL July 6 1924

20 UNDERTAKER John O. Mitchell ADDRESS 120 W Fayette St

(OVER)

Spec.—1-10-21—M&T—1500 Bks.

D 88295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Orleans ST., 5 WARD)

REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ellis

(a) RESIDENCE No. 1223 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winter Park, Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Aaron Jaggins 1223 Orleans St

15 JUL 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1924 to 6/30, 1924.

That I last saw him alive on 6/28, 1924

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Torpid liver

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: winter Park Va

DATE OF BURIAL: July 3 1924

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88296

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 88296

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1503 N Stricker St ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Era P Young

(Residence in Baltimore: No. 1503 N Stricker St St.: yrs., 4 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Feb (Month) 25 (Day) 1924 (Year)

7-AGE, ...yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER. Daniel Young

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Beatrice Walker

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beatrice Young

(Address) 1503 N Stricker St

15- Filed JUL 2 - 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) No history of Jaundice Symptoms or Cyanosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. E. J. Hennessy M. D. (Coroner)

July 1 1924 (Address) 2 E Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL July 2, 1924

UNDERTAKER Hammond & Wright

ADDRESS 1364 N Carey

IMPORTANT.—The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88297 HEALTH DEPARTMENT—CITY OF BALTIMORE 88297

1824
64
1860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp. ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Holland

(a) RESIDENCE NO. 1630 Presbury ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Holland

6 DATE OF BIRTH (month, day and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Day) 50

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abraham Holland

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Robinson

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Md

14 Informant Louis Hawkins

(Address) 1631 Presbury

Filed JUL 2 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to June 30, 1924,

that I last saw him alive on June 30, 1924,

and that death occurred, on the date stated above, at 8:20A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

Gangrene Leg (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dyberg, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL July 3rd 1924

UNDERTAKER Clarence E. Wright — ADDRESS 1364 Mary.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88298

CERTIFICATE OF DEATH.

90 D 88298

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pimlico Road & Ridge St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Burgess

(Residence in Baltimore: No. 1708 E. Monument St. or Pimlico Rd St.; 71 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, April (Month) 3rd (Day) 1853 (Year)

7-AGE, 71 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Policeman
(b) General nature of industry, business, or establishment in which employed (or employer) 061

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Jas. R. Burgess

11-BIRTHPLACE OF FATHER (State or Country), Easton Md

12-MAIDEN NAME OF MOTHER Emma McKim

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura R. Hodges

(Address) 678 N. Broadway

15-

JUL 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1924 (Year)

17-I HEREBY CERTIFY, That I attended deceased from September 1923, to June 29 1924, that I saw h~~im~~er alive on June 29 1924, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) ~~anaemia~~ & debility

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) L. Blount M. D.

June 30, 1924 (Address) 865 W. 36th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, July 2, 1924

20-UNDERTAKER Theo. E. Franck — ADDRESS 501 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88299

CERTIFICATE OF DEATH.

90 D 88299

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malinda Hopkins

(a) RESIDENCE NO. 1523 E. fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Hopkins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fannie Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Francis Austin (Gaughter)
(Address) 1523 E. Fayette St

File JUL 2 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency
(Valvular or Myocardial)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Watkins, M. D.
(Coroner.)

6/30/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: [illegible] 1924

20 UNDERTAKER: John F. Owens — ADDRESS: 575 [illegible]

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88300

CERTIFICATE OF DEATH.

90 D 88300

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 S. Eutaw St. ST. 21 WARD)

2-FULL NAME Cornelius Johnson. (C)

(a) RESIDENCE NO 1012 S. Eutaw St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced, HUSBAND of Emma Johnson. (C)

6 DATE OF BIRTH (month, day, and year) May, 8, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Johnson. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Rachael Walker. (C)
(Address) 1012 S. Eutaw St.

15 Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July, 2, 1924 (Address) 1817 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn ct — DATE OF BURIAL July 2 1924.

20 UNDERTAKER S. P. Brown & Son — ADDRESS 1018 W. Pratt St.

Spec.—1-10-21—M&T—1500 Blks.

D 88301 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Oscar Elvedge Davis

(a) RESIDENCE No. Marine Hospital ST., WARD Baltimore, Md.
(Usual place of abode) 1716 E. Baltimore
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed~~, or ~~divorced~~
HUSBAND of
~~(or) WIFE of~~ Mrs Nellie Davis

6 DATE OF BIRTH (month, day, and year) May 28 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	30	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ezra Transportation Co

9 BIRTHPLACE (city or town) Edna
(State or country) Effingham Co Ill

PARENTS

10 NAME OF FATHER Jasper Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) York Co Pa

12 MAIDEN NAME OF MOTHER Julia Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bullock Co Ga

14 Informant Wife
(Address) 1716 North Eutaw St

15 Filed JUL 2 - 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to June 29, 1924.

that I last saw him alive on June 29, 1924,

and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary
Tuberculosis (duration) 1 yrs. 5 mos ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Aboard ship

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic.

(Signed) W. H. Foster M.D.

6/29 1924 (Address) Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	7/2 1924
20 UNDERTAKER	ADDRESS
Sol Levinson & Bro	E Balto St

MARGIN RESERVED FOR BINDING No 1280

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88302

CERTIFICATE OF DEATH.

74-001

D 88302

Registered No.....

1-PLACE OF DEATH 1836 N. Carolina St

City of BALTIMORE: (No. 1836 N. Caroline St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine Penta

(a) Residence No. 1836 N Caroline St., 8 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 16 1839

7-AGE, 84 yrs. 10 mos. 15 ds. If LESS than 1 day, ... hrs. or ... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House work

(b) General nature of Industry, business, or establishment in which employed (or employer). Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Daniel Penty

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER Martha Hare

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co Md

14- (Informant) Mary Knuffler

(Address) 1836 N. Caroline St

15- JUL 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1924 to June 29, 1924

that I last saw her alive on June 29, 1924

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Duration unknown

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Visual Clinical data

(Signed) C. L. Meadows, M. D.

June 30, 1924 (Address) 1540 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL, 7/2, 1924

20-UNDERTAKER. George J. Reist

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 88303

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., 13 WARD)

2-FULL NAME William F. Wheatley

(a) RESIDENCE NO. 1934 Mt. Royal Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Rolland

6 DATE OF BIRTH (month, day, and year) March 20 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Broker Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maryland.

PARENTS

10 NAME OF FATHER James F. Wheatley

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Christina Bowling

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland.

14 Informant Mary Wheatley (Address) 1934 Mt Royal Ave

15 Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to July 1, 1924, that I last saw him alive on July 1, 1924, and that death occurred, on the date stated above, at 6.22 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis (duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of June 21, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic examination

(Signed) ..... M. D.

July 1. 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	7/4 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

Peroutka

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88304

1725 D 88304

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Frank Peroutka

(a) RESIDENCE NO. 2302 E. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 2 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 20th - 1923

7 AGE — Years 10 Months 9 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Peroutka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Elise VanDiver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Burials Johns Hopkins Hospital

15 Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 29, 1924, that I last saw h— alive on June 29, 1924, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Cervical Adenitis, Acute

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Diarrhea & Vomiting

(duration) ..... yrs. ..... mos. 18 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 7

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund N. Kerper, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 2 1924

20 UNDERTAKER Wm C. Miller — ADDRESS 2334 Eastern Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88305

CERTIFICATE OF DEATH.

129 D 88305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 E Pleasant St. ST., 17 WARD)

2-FULL NAME George Williams

(a) RESIDENCE No. 428 E. Pleasant St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dist Knad

6 DATE OF BIRTH (month, day, and year) September 6th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) Centerville (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Dulsol

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Linia Williams Mother (Address) 428 E. Pleasant St

15 JUL 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1924, to June 29th, 1924, that I last saw h[illegible] alive on June 29th, 1924, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam

(Signed) Geo H. Montgomery M.D. M. D.

6/30 1924 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Cemetery	July 2 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1925 Eastern

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88306

CERTIFICATE OF DEATH.

23 D 88306

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Murray

(a) RESIDENCE. NO. 1124 Oakley ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ø

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records
(Address)

15 Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-21, 1924, to 6-29, 1924, that I last saw him alive on 6-29, 1924 and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) ... yrs. ... mos. ? ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Drane, M. D.

6-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Funeral Cemetery	June 192
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Pitcher St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88307

CERTIFICATE OF DEATH.

D 88307

13 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 805 Newington Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Engelhaupt

(a) Residence No. 805 Newington Ave. St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH* (month, day and year) Jan 1st. 1847

7-AGE. 77 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Adam Engelhaupt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary E. Stuckert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant) Miss Engelhaupt

(Address) 805 Newington Ave.

15-Filed JUL 2 - 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1923 to June 30th 1924 that I last saw h.. alive on June 30th 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(Duration) ... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(Duration) 10 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas M. D

July 1st 1924 (Address) 830 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Park Cemetery	July 2..... 1924
20-UNDERTAKER. Chas F. Evans & Son	ADDRESS 118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88308

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2418 Arunah Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Murphy

(a) Residence No. 2418 Arunah Ave. St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret W. Murphy

6-DATE OF BIRTH (month, day and year) July 8th. 1856

7-AGE. 67 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chief Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Appeal Tax Court

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Peirce Murphy

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Margaret Doyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Margaret W. Murphy.

(Address) 2418 Arunah Ave.

JUL 2 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 30 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 6 - 1924 to June 30 - 1924

that I last saw living on June 29 1924

and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(Duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

7/1/24 19 (Signed) [signature] M. D

(Address) 1117 Mulberry [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery.	July 3 '24

20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88309

CERTIFICATE OF DEATH.

162 D 88309

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 S Pequeter St., 7 WARD)

2-FULL NAME Baby Burch

(a) RESIDENCE No. 409 S Pequeter ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 0 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/1/24

7 AGE Years ..... Months ..... Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Burch

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Fanny Franke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Henry Burch
(Address) 409 S Pequeter

Filed JUL 2 - 1924 19.....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 7/1, 1924, to 7/2, 1924,

that I last saw h[illegible] alive on 7/2, 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Postsyphilitic Marasmus

Prematur

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Abnormal Labor

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Hydrocephalus

(Signed) Blasius Strauch M. D.

, 1924 (Address) 320 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. — DATE OF BURIAL July 2" 1924

20 UNDERTAKER M. J. Sadowski — ADDRESS 705 S. Ann St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 88310 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2329 E. Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna M. Dieter

(a) Residence No. 2329 E. Chase St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Dieter

6-DATE OF BIRTH (month, day and year) Dec. 23-1883

7-AGE. 40 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER. Bernard Hasse

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Wilhelmina Meusch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant). John W. Dieter

(Address). 2329 E. Chase St.

JUL 2 - 1924 Filed. 192. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 29-1924

17- I HEREBY CERTIFY, That I attended deceased from June 21, 1924 to June 29, 1924 that I last saw h— alive on June 29, 1924 and that death occurred, on the date stated above, at 6-45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxl

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Course

(Signed) O. L. Long M. D.

430, 1924 (Address) 1701 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Lorraine Cem.	July 2, 1924
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88311

CERTIFICATE OF DEATH.

74-001 ✓ D 88311

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3404 Fait ave St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Seybold

(a) Residence No. 3404 Fait ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Seybold

6-DATE OF BIRTH (month, day and year) Mch. 15. 1865

7-AGE. 59 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Chas Festermann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Susana Uhland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) John Seybold

(Address) 3404 Fait ave

15- Filed JUL 2 - 1924 19.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 30-1924

17- I HEREBY CERTIFY, That I attended deceased from June 20 19 24 to June 30 19 24

that I last saw h.. alive on June 20 19 24

and that death occurred, on the date stated above, at. 9:35 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 2 hours hrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Indefinite mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry B. Athey M. D.

7/1/24 (Address) 2504 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cemetery — DATE OF BURIAL. July 3 19 24

20-UNDERTAKER. Zirkler & Zirkler — ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 88312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 88312 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Sima

(a) Residence No. 530 N. Curley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 22-1911

7-AGE, 12 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto., Md

PARENTS.

10-NAME OF FATHER, Emil Sima

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14-(Informant) Emil Sima

(Address) 530 N. Curley

JUL 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2-1924

17- I HEREBY CERTIFY, That I attended deceased from 6-30, 1924, to 7-2, 1924

that I last saw him alive on 7-2, 1924

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(Duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H. V. Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakhill Cem. DATE OF BURIAL. July 3, 1924

20-UNDERTAKER. Zurkler & Zurkler ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88313

CERTIFICATE OF DEATH.

129 D 88313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp ST., 15 WARD)

2-FULL NAME Mr Thomas Johnson.

(a) RESIDENCE No. 1370 Whatcoat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) March 9, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hod carrier. 035

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. f. Co Maryland.

PARENTS

10 NAME OF FATHER: Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co Maryland

12 MAIDEN NAME OF MOTHER: Rachel Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Maryland

14 Informant: Elenora Waters

(Address): 1370 Whatcoat St.

15 Filed JUL 2 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-11-24, 19 , to 6-29 , 1924.

that I last saw he/she alive on 6-29 , 1924,

and that death occurred, on the date stated above, at 11 25 a. m.

The CAUSE OF DEATH* was as follows:

Anterior chancre

Chr. Myocarditis

Chr. diffuse nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary): Acute dilatation. 10 min

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Compton, M. D.

, 19 (Address) Md Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery.	July 3 1924
20 UNDERTAKER: Wm S Jas. H. Dennis per T. E Kelson	ADDRESS: 1203 Pesstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88314 — 7 4 D 88314

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Stauffer

(a) RESIDENCE. No. Cross + Light St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John L Stauffer

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Fogle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Municipal Hospital Records
(Address)

15 Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1 192[illegible]

17 I HEREBY CERTIFY, That I attended deceased from 6-19 , 192[illegible], to 7-1 , 192[illegible]
that I last saw her alive on 7-1 , 192[illegible],
and that death occurred, on the date stated above, at 9 25 a. m.
The CAUSE OF DEATH* was as follows:

Senile Deterioration
Cerebral Hemorrhage (Right Hemiplegia) (duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? ~~Autopsy~~ Lab.

(Signed) Claude B. Bruce, M. D.

7-1, 192[illegible] (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	7-3 192[illegible]
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E Wash St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 88315

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Riley

(a) RESIDENCE. No. 317 S. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 JUL 2 - 1924 ROBERT R. KRAUTER, Registrar
1574 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28 192X

17 I HEREBY CERTIFY, That I attended deceased from 6-27, 192X, to 6-28, 192X, that I last saw her alive on 6-28, 192X, and that death occurred, on the date stated above, at 10 50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uremia

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Drane, M. D.

6-28 192X (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUL 2 - 192

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

206

Spec.—1-10-21—M&T—1500 Blks.

D 88316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 88316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Mc Elderry ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nina Robinson

(a) RESIDENCE NO. 1627 Mc Elderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of Chas Robinson

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homestead Dr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co Md

PARENTS

10 NAME OF FATHER Major Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary Co Md.

12 MAIDEN NAME OF MOTHER Sophia Rustin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary Co Md.

14 Informant Sophia Bennett (sister) (Address) 1627 Mc Elderry St

15 Filed JUL 2 - 1924 ROBERT R. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 29, 1924, that I last saw her alive on June 29, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Thyroid.

(duration) yrs. 4 mos 6 ds. according to Hist.

CONTRIBUTORY (Secondary) Hemorrhage from growth

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Godwin, M. D.

7/2, 1924 (Address) 720 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Miller's Wharf St Mary's Co Md — DATE OF BURIAL July 3 1924

20 UNDERTAKER Robert E Williams — ADDRESS 1515 Mc Elderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88317

CERTIFICATE OF DEATH.

D 88317

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

2-FULL NAME Ufarion Matthews

(a) RESIDENCE NO. Thurmont, Md. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jacob G. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Knott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs L. C. Yeager

(Address) Thurmont Md

Filed JUL 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to July 2, 1924, that I last saw her alive on July 1, 1924, and that death occurred, on the date stated above, at 6:40 am

The CAUSE OF DEATH* was as follows:

Acute Suppurative Pelvic Peritonitis

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Unresolved Pneumonia, Pleurisy & Effusion

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 6-30-24

Was there an autopsy? No

What test confirmed diagnosis? Gyn. & Clinical

(Signed) B. M. Hartigan, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Md — DATE OF BURIAL July 4th, 1924

20 UNDERTAKER Wm J Eckner & Son — ADDRESS Roth & Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88318

CERTIFICATE OF DEATH.

8 21 D 88318 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1943 N. Collington Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Olive M Deaks

(a) Residence No. 1943 N. Collington Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 9 1874

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry W Shelley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Carroll Co Md.

12-MAIDEN NAME OF MOTHER, Laura Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Laura E Shelley

(Address) 1943 Collington Ave

15- JUL 2 - 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 30th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to June 30, 1924, that I last saw h alive on June 30, 1924, and that death occurred, on the date stated above, at 2.20 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frahm, M. D.

7/1, 1924 (Address) 1823 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemty — DATE OF BURIAL, July 2, 1924

20-UNDERTAKER, Robt J Turner Jr — ADDRESS 4 Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88319

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1134 Riverside Ave St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah H. Stansbury

(a) RESIDENCE. NO. 1134 Riverside Ave St.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 28. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or 4 min.
	49	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jonah Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stonesifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Ida Lavory 1134 Riverside

15 FILED JUL 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to July 1, 1924.

that I last saw him alive on July 1, 1924.

and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Catarrh of Bronchus

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Mitchell, M. D.

July 2, 1924 (Address) 1734 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	7/4/1924
20 UNDERTAKER	ADDRESS
J. J. Baker & Sons	318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88320

CERTIFICATE OF DEATH.

100-901 D 88320

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2105-N-Calvert St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benjamin Owen Hance

(a) Residence No. 2105-N-Calvert St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 54 yrs. 9 mos. 0 ds.

THIS IS A PERMANENT RECORD AND MUST BE FILLED IN WITH UNFADING INK—THIS IS ESPECIALLY REQUESTED. PHYSICIANS should write PLAINLY, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Myrtle Hobbs Hance

6-DATE OF BIRTH (month, day and year) Oct-1-1869

7-AGE. 54 yrs. 9 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Supt of the Carriage Toy Co.

(b) General nature of Industry, business, or establishment in which employed (or employer). Carriage Toy Co.

(c) Name of employer. Carriage Co.

9-BIRTHPLACE (city or town) (State or Country). Calvert Co. Maryland

PARENTS.

10-NAME OF FATHER. Benj. Hance

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Calvert Co. Maryland

12-MAIDEN NAME OF MOTHER. Arianna Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Calvert Co. Maryland

14- (Informant) Mrs Myrtle H. Hance wife

(Address) 2105 N. Calvert St

15- ROBERT R. KRAUTER

Filed ..... 192 Registrar.

JUL 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1st, 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 4th, 1924, to July 1st, 1924, that I last saw h.m alive on June 30th, 1924, and that death occurred, on the date stated above, at 1.15 A. m. The CAUSE OF DEATH* was as follows:

a Broncho Pneumonia

about 4 weeks (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Health Dept Laboratory Tests, and X Rays

(Signed) Henry M. Bayley, M. D.

7/1/24. 19 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wilson-Calvert Co Md

DATE OF BURIAL. July 3, 1924.

20-UNDERTAKER. STEWART & WOODEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88321

CERTIFICATE OF DEATH.

129 D 88321

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 E Federal ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Tassel

(a) RESIDENCE NO. 1218 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Jennie Tassel

6 DATE OF BIRTH (month, day, and year) Feby 18th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER George Tassel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Batzebuhler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jennie Tassel (Address) 1218 E Federal St

15 JUL 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. , 1923 , to July 1 , 1924 .

that I last saw him alive on June 30 , 1924

and that death occurred, on the date stated above, at 11 PM.

The CAUSE OF DEATH* was as follows:

Myocarditis with Dilatation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

7/3/1924 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 5th 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88322 ✓ D 88322

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 Edmondson Ave ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Richard Cook

(a) RESIDENCE. No. 1327 Edmondson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. -

PARENTS

10 NAME OF FATHER Fillmore Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. -

12 MAIDEN NAME OF MOTHER Catherine E. Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Fillmore Cook
(Address) 1327 Edmondson Ave

15 Filed JUL 2 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to July 3, 1924, that I last saw him alive on July 2, 1924, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsion due to Cortical Irritation.
actual cause unknown
4 hours
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY —
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? visual

(Signed) Geo A Travers, M. D.

7/3, 1924 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 3 1924

20 UNDERTAKER Josiah Syfer ADDRESS 1601 W. North Ave

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Nelson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88323

CERTIFICATE OF DEATH.

D 88323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A Nelson

(a) RESIDENCE NO. Simpsonville ST., WARD Simpsonville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) Simpsonville (State or country)

14 Informant Hosp Records.
(Address)

15 Filed JUL 2 1924 Robert P. Harrison, Registrar
, 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-1, 1924 to 7-2, 1924

that I last saw him alive on 7-2, 1924

and that death occurred, on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:

Edema, Acute tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

20 UNDERTAKER Easton Sons

DATE OF BURIAL July 4 1924

ADDRESS Ellicott City

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Valentina Jasinski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88324

49 D 88324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., V WARD)

2-FULL NAME Mrs. Valentina Jasinska

(a) RESIDENCE NO. 237 S. Wolfe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1822

7 AGE: Years 102 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Kluczynska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records (Address)

15 7-2-1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/24

17 I HEREBY CERTIFY, That I attended deceased from 3/6/24, 19..., to 7/1/24, 19..., that I last saw h... alive on 7/1/24, 19..., and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Kidney

?

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 6/27/24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) K. W. Lalley, M. D.

7/1, 1924 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary | DATE OF BURIAL 7/3 1924

UNDERTAKER William Fallsworth ADDRESS 618 Eastern Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88325

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Park ave ST., Raspeburg WARD)

2-FULL NAME Mrs Margareth Schiller

(a) RESIDENCE NO. 114 Park ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schiller

6 DATE OF BIRTH (month, day, and year) May 18th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Strobel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Arthie E. Simon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Schiller (Address) 1125 Park ave Raspeburg

15 JUL 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19 1924, to July 2nd 1924, that I last saw h alive on July 2nd 1924, and that death occurred, on the date stated above, at July 2nd 9 a.m.

The CAUSE OF DEATH* was as follows:

Sclerosis of the Liver and Cirrhosis with Chronic Nephritis Interstitial

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

Renal (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her Residence

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms + Presumptive

(Signed) George C. E. Boyle, M. D.

1924 (Address) 10 N. Fulton Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	July 5, 1924
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88326
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15 74 001

D 88326
Registered No.

City of BALTIMORE: (No. 4211 Park Heights Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Linah

(a) Residence No. 4211 Park Heights Ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David Linah

6-DATE OF BIRTH (month, day and year) Nov. 12, 1837

7-AGE: 86 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Carroll Co., Md.

PARENTS.

10-NAME OF FATHER: Andrew Kuhn

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Carroll Co., Md.

12-MAIDEN NAME OF MOTHER: Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-
(Informant): Miss Leitha Linah
(Address): 4211 Park Heights Ave.

15-
JUL 3 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

Via Automobile

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 2 1924

17- I HEREBY CERTIFY, That I attended deceased from June 24 1924 to July 2 1924
that I last saw h[illegible] alive on July 2 1924
and that death occurred, on the date stated above, at 10:15 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Hemiplegia (left)

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(Duration) [illegible] yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S Adelmot M. D
7-2-, 1924 (Address) 4012 Park Heights av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Taneytown, CarrollC. Md. | DATE OF BURIAL: July 4 1924

20-UNDERTAKER: Henry W. Mears & Son | ADDRESS: 805 N. Calvert

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

88327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 88327

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 530 N. Montford Ave ST.; 1 WARD)

2-FULL NAME Octavia L. Sauers

(a) RESIDENCE. No. 530 N Montford Ave, ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 50 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fredrick Sauers

6 DATE OF BIRTH (month, day, and year): May 14 - 1866

7 AGE: Years 58 Months 1 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wicomico Co. Md.

PARENTS

10 NAME OF FATHER: Levin B. Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wicomico Co Md.

12 MAIDEN NAME OF MOTHER: Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wicomico Co Md.

14 Informant: Fredrick Sauers (Address) 530 N. Montford Ave.

15 FILED JUL 3 - 1924 ROBERT R. KRAUTER, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to July 1, 1924, that I last saw her alive on July 1, 1924, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH was as follows:

Chronic Arterial Hypertension

Hemiplegia (Right Side)

Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma - Myocardial Degen.

(duration) yrs. mos. 3 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) # W. Sauers M. D.

19 (Address) 5414 Melton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Cem. Wicomico Co

DATE OF BURIAL: July 3 1924

20 UNDERTAKER: Mrs C. Miller

ADDRESS: 2334 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88328

CERTIFICATE OF DEATH.

129

D 88328

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 904 S. Fourth St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Caroline Guntensperger

(a) Residence No. 904 S. Fourth St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alfred Guntensperger

6-DATE OF BIRTH (month, day and year) Sept. 6-1858

7-AGE. 65 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Conrad Lemmenlitzer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Fredericka Fredericks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Alfred Guntensperger

(Address) 904 S. Fourth St.

15- Filed JUL 3 - 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1-1924

17- I HEREBY CERTIFY, That I attended deceased from 6/13/24 19.. to 7/1/24 19..

that I last saw her alive on 6/30 19.24

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis (chronic)

Myocarditis

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) ..yrs. 3 mos. ..ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. McConnell M. D.

4/1/24 (Address) 635-S-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakland Cemetery — DATE OF BURIAL. July 3 19.24

20-UNDERTAKER. Zickler & Zickler — ADDRESS 1739 E. Eager St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--1-12-23--M&T--100 Bks.

D 88329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88329

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3232 Lyndale Ave ST. 96 WARD)

2-FULL NAME Annie E. Rice

(a) RESIDENCE NO. 3912 Maine Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick M Rice

6 DATE OF BIRTH (month, day, and year) Aug 30. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Hissey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant F. M. Rice
(Address) 3912 Maine Ave.

15 JUL 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an July Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Caediac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis (duration) yrs. mos. ds.

(Signed) J. S. Pollen, M. D.
(Coroner.)

7/2/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 3rd 1924

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88330

74-001 D 88330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 204 Oakley ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Schaumloeffel

(a) Residence No. 204 Oakley ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 1 mos. — ds How long in U. S., if of foreign birth? 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of [illegible] Elizabeth

6-DATE OF BIRTH (month, day and year) Dec 26 1846

7-AGE, 77 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) John Roach & Sons Washington

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Louis Knorr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Kurr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Charles W. Schroeder

(Address) 204 Oakley ave

15-JUL 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1st 1924

I HEREBY CERTIFY, That I attended deceased from June 30, 19 24, to July 1, 19 24, that I last saw h[illegible] alive on June 30, 19 24, and that death occurred, on the date stated above, at 6.15 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Chas W. Bubert M. D.

July 2 1924 (Address) 1104 E Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, 8/3/24 19....

20-UNDERTAKER Geo Weber & Son ADDRESS 2503 Edmondson ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

88331 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL WARD) REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Duffy.

(a) RESIDENCE (Usual place of abode) NO. 1401 Division ST., St. WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: W. | 5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 27 1924

7 AGE — Years: 0 | Months: 2 | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 1 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to July 1, 1924, that I last saw him alive on July 1, 1924, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Vincent's Infant Asylum

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. A. Wesch, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leatherdale — DATE OF BURIAL July 3 1924

20 UNDERTAKER W. Bailey Sons — ADDRESS 1877 N. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88332

185 D 88332

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1774 Montpelier ST., 9 WARD)

2-FULL NAME Archibald Bien

(a) RESIDENCE No. 1774 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 6/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John H.Bien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto .Md

12 MAIDEN NAME OF MOTHER Sarah C. [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Frank Bien (Address) 1774 Montpelier

15 Filed JUL 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-fell down stairs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Vertigo

Senerial yrs. mos. ds.

(Signed) J. Wm Cale, M. D.
(Coroner.)

7/3/24, 192 (Address) 508 E E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 7/3 1924

20 UNDERTAKER George J. Ruth 1755 ADDRESS Harford Av

CAUSE OF DEATH is to be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-24—M&T—1500 Blks.

1327 D 88333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60 D 88333

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Gruenmer

(a) RESIDENCE NO. 1433 Webb ST., St WARD 4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred also 50 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? 60 yrs. ~ mos. ~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (H~~usband~~) of the late George Gruenmer,
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Doty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Josephine Krauss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 JUL 3 - 1924 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to July 2, 1924, that I last saw h~~e~~r alive on July 2, 1924, and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 10 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) ~ yrs. 6 mos. ~ ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ary Jacobson, M. D.

(Address) 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 5 1924

20 UNDERTAKER Henry Hoech Son — ADDRESS 1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88334

CERTIFICATE OF DEATH.

90 D 88334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4722 York Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernadina Moller

(a) RESIDENCE No. 4722 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: the late John. L. Moller

6 DATE OF BIRTH (month, day, and year): Nov. 20 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Mr. Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr Lawrence J. Moller

(Address) 2314 E Preston St

15 Filed JUL 3 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from June 14 1924 to July 1st 1924

that I last saw h alive on July 1st 1924

and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Duration day definitely

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. S. Lowe, M. D.

July 7, 1924 (Address) 1507 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 5 1924

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1130 E Eager St

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88335

CERTIFICATE OF DEATH.

16 D 101
D 88335

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 864 N. Howard st., 11 WARD)

2-FULL NAME Wilhelm C. Juncker

(a) RESIDENCE No 864 N. Howard St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 19-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	~~11~~	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Ger.
(State or country)

PARENTS

10 NAME OF FATHER John Juncker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Deutschland

12 MAIDEN NAME OF MOTHER (illegible)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Bertha Juncker
(Address) 2403 Eastern Ave

15 Filed JUL 3 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

..... (duration) ..... yrs. a few hours mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Gough, M. D.
(Coroner.)

7/3, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va.	July 3 1924
20 UNDERTAKER W. M. Roulson	ADDRESS 2238 N Howard

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec--12-23-21—E.B.R.S.—400 Blks.

D 88336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12/ D 88336

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 Edmondson Avenue St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Hildebrand

(a) Residence No. 1021 Edmondson Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F.Hildebrand

6-DATE OF BIRTH (month, day and year) Dec.30,1844

7-AGE, 79 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas McMechin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Sarah Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Henry F.Hildebrand

(Address) 1021 Edmondson Avenue

15-

Filed JUL 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 2,1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to July 1, 1924,

that I last saw him alive on July 1, 1924,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) My O. Cardits.

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) John A Evans, M. D.

7-2-, 1924 (Address) 101 N.Carey Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, ... 19....

20-UNDERTAKER, Joseph B Cook — ADDRESS 1003 W Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88337

CERTIFICATE OF DEATH.

44 D 88337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Ramsey St. 19 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Franz

(a) RESIDENCE. No. 1329 Ramsey St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 1st 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Balto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dot Uhrn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Catherine Franz

(Address) 1329 Ramsey St

15 JUL 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/23/24, 19..., to July 1, 1924, that I last saw h[illegible] alive on 6/23/24, 19..., and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Asthma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/4/24 (Address) 330 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 5 19
20 UNDERTAKER	ADDRESS
John J Fields	2300 W Lombard

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88338

CERTIFICATE OF DEATH.

179 D 88338

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE. (No. St. Agnes Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elwood P. Bozel

(a) RESIDENCE No. 2503 Dulaney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1st 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Wm Bozel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susan C. Kally

BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

Informant Wm Bozel

(Address) 2503 Dulaney St

Filed: 192

Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body burned

2nd Degree

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Family does not know how Clothes got on fire

(duration) yrs. mos. ds.

(Signed) Thos. R. Hanlon M. D.
(Coroner.)

July 2nd 192 4 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 5 192 4
20 UNDERTAKER	ADDRESS
F. B. Heppe & Sons	2316 Eutaw Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88339

CERTIFICATE OF DEATH.

Registered No. D 88339

1-PLACE OF DEATH

City of BALTIMORE: (No. 2733 Raynor St., 16th Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melanethon Hebb Odell

(a) Residence No. 2733 Raynor Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary J. Odell

6-DATE OF BIRTH (month, day and year) Sept 15-1853

7-AGE. 70 yrs. 9 mos. 18 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk Mfg. 045
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer. Canada Tobacco

9-BIRTHPLACE (city or town) (State or Country) Springwood Va

PARENTS.

10-NAME OF FATHER. Abel Odell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Amherst

12-MAIDEN NAME OF MOTHER. Bethenia Bacon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

13 (Informant). Mary J. Odell

14 (Address). 2733 Raynor Ave

15 Filed ..... 192.. ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2-1924

17- I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to July 2, 1924, that I last saw him alive on July 2, 1924, and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Right Side Hemiplegia

(Duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis & Oedema of Lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chas. Eyland.

(Signed) John A. Wadland M.D.

7/3, 1924 (Address) 1219 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	July 5, 1924
20-UNDERTAKER.	ADDRESS
F. B. Stippert & Son	Park Ave & Baker St

CAUSE OF DEATH is very important. See instructions on reverse side.

Spec.—1-10-21—M&T—3500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88340

129 D 38340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 N. Carey (ST.,) 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cole

(a) RESIDENCE NO. 707 N. Carey (ST.,) 16 (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: col.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Jennie Cole

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE: Years 73 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Anything.

(c) Name of employer: Anybody.

9 BIRTHPLACE (city or town) (State or country): Near Gilboa, Md.

PARENTS

10 NAME OF FATHER: William Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Raymond Cole

(Address) 707 N. Carey St.

JUL 3 - 1924 ROBERT R. KRAUT, II Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/1/24

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 24 to July 1, 19 24

that I last saw him alive on June 30, 19 24

and that death occurred, on the date stated above, at 1.01 P. m.

The CAUSE OF DEATH* was as follows: Nephritis, chr.

General wks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Edema chr.

General wks

(duration) yrs. ds.

18 Where was disease contracted if not at place of death? Patient

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Allan Feld Bye M. D.

19 24 (Address) 421 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M.M. Gilboa Bur

DATE OF BURIAL: 7/3/24

20 UNDERTAKER: Dennis Easton

ADDRESS 916 Penna Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TYPE

U.S.A.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88341

CERTIFICATE OF DEATH.

D 88341

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Marie Manuel

(a) Residence No. 1801 N Monroe St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Manuel

6-DATE OF BIRTH (month, day and year) May 27 1844

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles F Walker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Annie Kiains

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Raymond Manuel

(Address) 1801 N. Monroe St.

15-

Filed JUL 3 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 18, 19 24, to July 3, 19 24

that I last saw h alive on 7/3/24, 19

and that death occurred, on the date stated above, at 4 05 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(Duration) yrs. (?) mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Harper M. D

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral	July 7, 1924
20-UNDERTAKER,	ADDRESS
George J Smith	Hollins at

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAKO

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88342

CERTIFICATE OF DEATH.

17 D 88342

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2806 Kennedy Ave. Ward 9)

2-FULL NAME Ella B. Busch

(a) RESIDENCE. No. 2806 Kennedy Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. W. Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Alice Jane Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Howard B. Livingston (Address) 2806 Kennedy Ave.

15 Filed ....., 19 JUL 3 - 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 19 22, to July 2, 19 24, that I last saw her alive on July 2, 19 24, and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Endocarditis

(duration) 2 yrs. - mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 2 yrs. - mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 15 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	July 5 19 24

20 UNDERTAKER George L. Ashman ADDRESS 2101 Pitcher Ave.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH D 88343 REGISTERED NO. D 88343

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Matthews

(a) RESIDENCE. No. 423 Stirling ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records
(Address)

15 JUL 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-9, 1924 to 7-1, 1924

that I last saw him alive on 6-30, 1924

and that death occurred, on the date stated above, at 2:15 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Incompetency
(Syphilitic Aortitis ?)
Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Drane, M. D.

7-1 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88344

100-001

CERTIFICATE OF DEATH.

D 88344

Registered No.....

1-PLACE OF DEATH Bay View Hospital 10

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Hnotm

(a) Residence No. 1005 Eager St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Bay View Hosp

(Address) Balto, Md.

15- A. Lane Registrar.

JUL 3 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 24 19 24 to June 30 19 24

that I last saw h alive on June 29, 19 24

and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

Arteriosclerosis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) N. E. Edmunds M. D.

, 19 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	July 3, 1924
20-UNDERTAKER,	ADDRESS
Mrs. R. G. Elliott	1725 Eastlandon.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9[illegible] 1000 Bks.

D 88345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88345

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Philadelphia R. ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Francis Smith

(a) RESIDENCE. No. 3011 Philadelphia R ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles G. Smith

6 DATE OF BIRTH (month, day, and year) Oct. 21st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. MD

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William F. Shaw.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Sarah J Rogers.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mildred F. Yockel.
(Address) 3011 Philadelphia Road

15 Filed JUL 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28 1924, to July 2 1924.

that I last saw h[illegible] alive on July 2 1924

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J. Sayser M. D.

(Address) 801 W Lanwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 5th 1924
20 UNDERTAKER	ADDRESS
William W. Shriver	1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88346

CERTIFICATE OF DEATH.

101

D 88346

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2001 Cliftwood Av St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Shortall

(a) Residence No. 2001 Cliftwood Av St., 8 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of late Michael Shortell

6-DATE OF BIRTH (month, day and year) Aug 9/1861

7-AGE, 62 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Ahern

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) John Shortall

(Address) 2001 Cliftwood ave.

15- Robert P. Harrison, Registrar.

Filed 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 2-24

17- I HEREBY CERTIFY, That I attended deceased from June 30, 1924 to July 2 1924

that I last saw her alive on July 2, 1924

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 da.

CONTRIBUTORY —

(Secondary)

(Durntion) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) D P Herzog MD

July 2, 1924 (Address) 1305 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood Cemetery

DATE OF BURIAL, July 5, 1924

20-UNDERTAKER, Geo. J. Ryan

ADDRESS 1730 Harford ave.

L3

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 88347 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 1297

City of BALTIMORE: (No. St. Agnes Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eliz. Scott.

(a) Residence No. Smith Ave Mt Washington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Patrick M Scott

6-DATE OF BIRTH (month, day and year) June 24 1866

7-AGE, 57 yrs. mos. 3 ds. | If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert Hoyland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Egins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Patrick Scott

(Address) Smith Ave Mt Washington

15- JUL 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1-1924

17- I HEREBY CERTIFY, That I attended deceased from 6-26- 1924, to 7-1 1924

that I last saw h[illegible] alive on 7-1 1924

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal Disease

Arteriosclerosis

Hypertension ?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. W. Harper, M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge | DATE OF BURIAL. July 4, 1924

20-UNDERTAKER, Elmer W. Conklin | ADDRESS 924 E. Eager

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88348 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88348

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 946 Harford Ave St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Catherine Mute.....

(a) Residence No. 948 Harford Ave St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 22nd 1924

7-AGE, ... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Salt Lake City

PARENTS.
10-NAME OF FATHER: Walter F. Mute
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Salt Lake City
12-MAIDEN NAME OF MOTHER: Georgia Harris
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Salt Lake City

14-
(Informant) Walter F. Mute
(Address) 948 Harford Ave

15-
Filed JUL 3 - 1924 Robert P. Harrison Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22nd 1924

17- I HEREBY CERTIFY, That I attended deceased from July 22nd 1924 to July 22nd 1924 that I last saw h.. alive on July 22nd 1924 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

6 1/2 hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sec. Stone

(Signed) ..... M. D.

July 23rd 1924 (Address) 150 S. Eaton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 3 1924

20-UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E Eager

10

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88349

CERTIFICATE OF DEATH.

74-001 D 88349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elenora Chapman

(a) RESIDENCE. No. 1033 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER David Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Sharp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records (Address)

Filed JUL 3 - 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-18, 1924, to 7-1, 1924

that I last saw her alive on 7-1, 1924

and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia, Residual

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clark G. Brack, M. D.

7-3, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 5 1924

20 UNDERTAKER Chris. H. Johnson ADDRESS 446 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88350

CERTIFICATE OF DEATH.

D 88350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Boone St., 9 WARD)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Baker

(a) RESIDENCE NO. 1607 Boone St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... no

(b) General nature of industry, business, or establishment in which employed (or employer) ... no

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Baker

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Maude Scott

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) Virginia

14 Informant ...
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... Robert P. Harrison, Registrar

JUL 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to July 3, 1924, that I last saw h... alive on July 3, 1924, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Physical condition of the mother and premature Birth

(duration) ... yrs. 9 mos ... ds.

CONTRIBUTORY (Secondary) Physical condition of mother (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo L Hall, M. D.

, 19 (Address) 4266 23d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... DATE OF BURIAL JUL 3 - 1924

20 UNDERTAKER Commissioner of Health. ADDRESS

For Wm. F. Woodall

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 707 East 21st St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary L Kilkenny

(a) Residence No. 707 E. 21st St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 1 - 1878

7-AGE. 45 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Kilkenny

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ellen J. Hanley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14-

(Informant) E. F. Kilkenny

(Address) 707 E. 21st St. City

15-

Filed JUL 3 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1 - 24

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to July 1, 1924

that I last saw her alive on June 30, 1924

and that death occurred, on the date stated above, at 3:45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Edema of Lungs + Exhaustion.

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? (Town)

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) William F Schwartz, M. D.

7/2, 1924 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
H. Ger. Cemetery Texas Md	July 4 1924
20-UNDERTAKER.	ADDRESS.
K. C. Wiedefeld	914 Greenmt Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88352

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 D 88352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 E. 33rd ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil G. Gruebel

(a) RESIDENCE NO. 201 E. 33rd ST., ... WARD .....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Gruebel

6 DATE OF BIRTH (month, day, and year) Aug. 11-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. F. Gruebel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Kesmodel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Gruebel

(Address) 201 E. 33rd St.

15 Robert P. Harrison, Registrar

L 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923 to July 2, 1924.

that I last saw h. alive on July 1, 1924,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Probably (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? X-Ray, Blood, etc.

(Signed) Martin F. Moore M.D.

(Address) 414 Prof. Bldg.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: July 5 1924

20 UNDERTAKER: Chas E. Franck ADDRESS: 502 Madison Ave

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 88353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88353

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 E Biddle ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda Elizabeth Seiss

(a) RESIDENCE NO. 1806 E Biddle ST., 8 WARD Eighth Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Joseph W. Seiss Deceased

6 DATE OF BIRTH (month, day, and year) Dec. 25 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63.	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Sharpsburg Md

PARENTS

10 NAME OF FATHER John Koetzey

11 BIRTHPLACE OF FATHER (city or town) Sharpsburg (State or country) Md

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) dont Know (State or country)

14 Informant Howard J. Seiss

(Address) 68 E 30th St Baltimore

15 JUL 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17

I HEREBY CERTIFY, That I attended deceased from June 27th, 1924, to July 3, 1924,

that I last saw her alive on July 3, 1924,

and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Paralysis due to

Blood clot on Brain

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Paralysed of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 1806 E Biddle

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas J Emmons, M. D.

July 3 1924 (Address) 1028 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md

DATE OF BURIAL July 3 1924

20 UNDERTAKER Zorkler & Zorkler

ADDRESS 1734 Eager

L3

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 88354

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3408 Rowlalan Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Adella Mickener

(a) Residence No. 3408 Rowlalan Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas S. Mickener

6-DATE OF BIRTH (month, day and year) Nov. 11, 1862

7-AGE. 61 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Phila Pa

PARENTS.

10-NAME OF FATHER, Edw. C. Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Elizabeth Hart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Mrs Amy R. Packer

(Address) 3408 Rowlalan Ave.

15- Dec 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1924 to July 3 1924

that I last saw h.. alive on July 1 1924

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic valvocarditi

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) as above.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jesse S. Bishop M. D

, 19 (Address) 980 N. Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Philadelphia Pa

DATE OF BURIAL, July 5 1924

20-UNDERTAKER Wm. J. Mickener Sons

ADDRESS North Pa

L 3

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 88355 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 44 D 88355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2601 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie A Griggs

(a) Residence No. 2601 N. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 1864

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Capt James E. Griggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Sarah J Wheeler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

11- (Informant) Mrs S E. Wheeler

(Address) 2601 N. Charles St

15- Filed L3 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 24 1924 to July 2 1924

that I last saw h.. alive on July 2 1924

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Watson M. D

July 3. 1924 (Address) 2128 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cem — DATE OF BURIAL. July 4. 1924

19-UNDERTAKER. John O. Mitchell — ADDRESS 201 W Fayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88356

CERTIFICATE OF DEATH.

3/4 D 88356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2903 W North ST. 15 WARD)

2-FULL NAME John Edward Ricks

(a) RESIDENCE No. 2903 W North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Ricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary J Orem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Wm Ricks

(Address) 2903 W North ave

15 Filed ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to July 1, 1924, that I last saw him alive on July 1, 1924, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wallace A Cox, M. D.

July 3 1924 (Address) 2406 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: July 5 1924

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1300 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88357

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 88357

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Williams

(a) RESIDENCE NO. Highside Ave ST. Woodlawn WARD Branch

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 1924

7 AGE: Years | Months | Days: 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Edna Tweedale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital.

15 Filed JUL 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1924 to July 3, 1924 that I last saw h[illegible] alive on July 3, 1924 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E Edmunds, M. D.

7/3, 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: 7/4 1924

20 UNDERTAKER: J. J. Gahey Sons — ADDRESS: 1318 Eighth Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88358

CERTIFICATE OF DEATH.

D 88358
Registered No.

1-PLACE OF DEATH St Agnes Hosp

City of BALTIMORE: (No. ..... St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dreyer

(a) Residence No. 229 E. Monument Parkway St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna A Dreyer

6-DATE OF BIRTH (month, day and year): Dec 8. 1851

7-AGE: 72 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ret'd Business man
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer: ...

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, J F C Dreyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna A Roderbeck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Anna A. Dreyer
(Address) 229 University Pkway

15- JUL 4 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 7/3/1924

17- I HEREBY CERTIFY, That I attended deceased from June 26, 1924, to July 3, 1924, that I last saw him alive on 7/3/24, 19..., and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows:

Mesenteric Coelosmus
operation

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - Malignancy Pancreas (?) (Duration) ... yrs. ? mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/30/24

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H W Draper, M. D
, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon P/K | DATE OF BURIAL: 7/6/24

20-UNDERTAKER: Wm Chas L Rohde | ADDRESS: 600 Arlington Ave

IMPORTANT. Information must be printed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 88359

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-D 88359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 110 N. Poppleton ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Sheppard

(a) RESIDENCE. No. 110 N. Poppleton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of James H. Sheppard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W. Carrick

(Address) 856 W. Balto St.

15 Filed JUL4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to July 3, 1924, that I last saw her alive on July 3, 1924, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & Myocarditis duration 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Ode M. D.

July 4. 1924 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	7/5/24
20 UNDERTAKER	ADDRESS
Hugo J Smith	1533 Aisquith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88360

CERTIFICATE OF DEATH.

129 D 88360

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2836 Hunington Ave St.) (7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Pillsbourth

(a) Residence No. 2836 Hunington St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1840

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Ireland

PARENTS.

10-NAME OF FATHER William O'Keffe

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Sullivan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Laura Schuung

(Address) 2836 Hunington

15- JUL 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3, 24

17- I HEREBY CERTIFY, That I attended deceased from June 1924 to July 2, 1924

that I last saw h— alive on July 2, 1924

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Louis Adler, M. D.

7/3, 1924 (Address) 2406 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal:** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral	July 5, 1924
20-UNDERTAKER.	ADDRESS
M. Daly & Son	1011 W. North

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 88361 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88361

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 609 Washington St. Blvd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry James Moseman

(a) Residence No. 609 Washington Blvd Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Kate Moseman

6-DATE OF BIRTH (month, day and year) April 4 1852

7-AGE. 72 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Produce
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dealer
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Moseman

11-BIRTHPLACE OF FATHER (city or town) (State of Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Allen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant)..... Kate Moseman

(Address)..... 609 Washington Blvd

JUL 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2 1924

17- I HEREBY CERTIFY, That I attended deceased from June 26 19 24 to July 2 19 24

that I last saw him alive on July 2nd 19 24

and that death occurred, on the date stated above, at 6.58 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J. F. Poulton M. D.

9/3/24 19 (Address) 3909 Gamewell Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. | DATE OF BURIAL, July 5, 1924

20-UNDERTAKER, Jos Jacobs & Son | ADDRESS 2178 Pres

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 88362

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 88362

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 John St ST., 14 WARD)

2-FULL NAME Melvin Lee Miller

(a) RESIDENCE NO. 1605 John ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen E. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mc Shea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Caroline Miller

(Address) 1605 John St

15 JUL 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to July 2, 1924, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Aneurysm of Aota

(duration) 5 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Rupture of Aneurysm

(duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Carbaugh M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middletown Md Cem	July 5 1924
20 UNDERTAKER	ADDRESS
E L Roy Shiffler	R 5 E North Ave

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. AGE should be stated in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 88363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88363

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2nd Gen Hospital (St.) 9 (WARD)

2-FULL NAME Robert E. Blatchley

(a) RESIDENCE NO. 2567 Freemount Ave WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Blatchley

6 DATE OF BIRTH (month, day, and year) Dec 10 1848

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired Contractor

(c) Name of employer o/b

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw Blatchley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emberson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant George Blatchley

(Address) 2567 Freemount Ave

JUL 5 - 1924 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.2.24 19

17 I HEREBY CERTIFY, That I attended deceased from 6.30.24 19 to 7.2.24 19

that I last saw him alive on 7.2.24 19

and that death occurred, on the date stated above, at 5-20 a m.

The CAUSE OF DEATH* was as follows:

a. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema 2 hrs

Acute Cardiac Dilatation 20 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Dempsey, M. D.

....., 19 (Address) 2nd Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery Govans	7/5 1924
20 UNDERTAKER George J Ruth	ADDRESS 1730 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88364

CERTIFICATE OF DEATH.

75 D 88364

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1840 W. Mulberry ST., 20 WARD)

2-FULL NAME Miss Mary Jane Bradford

(a) RESIDENCE NO. 1840 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct. 16th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	8	18	

8 OCCUPATION OF DEDECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Bel Air
(State or country) Md.

PARENTS

10 NAME OF FATHER Jas Bradford

11 BIRTHPLACE OF FATHER (city or town) Eng.
(State or country)

12 MAIDEN NAME OF MOTHER Rachel Lawson

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Mrs Jessie E. Simmons
(Address) 1840 W Mulberry St

15 Filed JUL 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1923, to July 4, 1924, that I last saw her alive on July 2nd, 1924, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Severe paralysis in Apr. 1923 unable to speak or walk since that time

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Grad Wandering Nasling

(duration) yrs. ..... mos. 16 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E A Smith, M. D.

July 7, 1924 (Address) 1605 W North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	July 5 1924
20 UNDERTAKER Harry W. Eshleman	ADDRESS 1944 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NK—THIS IS A PERMANENT RECORD. Every item of infor-

Cor.—1-12-23—M&T—100 Pks.

38365 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 38365

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Bruce ST., 19 WARD)

2-FULL NAME Thos M. Collins

(a) RESIDENCE NO 204 N. Bruce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 8th /24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence Collins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Coates

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Alice Collins
(Address) 204 N. Bruce St

15 Filed ..... Registrar

JUL 5 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition
(duration) since birth yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Norton, M. D.
(Coroner.)
July 2nd 1924 (Address) Curtis Bay Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.P. Cemetery	7/5/24
20 UNDERTAKER David Garland	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88366 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 578½ Brunswick St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac Brown

(a) Residence No. 578½ Brunswick St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) 1863.

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Odd

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Anne Arundel Co. Md

PARENTS.

10-NAME OF FATHER. George Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Anne Arundel Co Md

12-MAIDEN NAME OF MOTHER. Lucy Jennings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Anne Arundel Co Md

14-(Informant). Mrs Mamie Brown

(Address). 578½ Brunswick St

15-JUL 5 - 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3 1924

17- I HEREBY CERTIFY, That I attended deceased from July 2 1924 to July 3 1924

that I last saw him alive on July 3 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. F. Mackey M. D.

, 19 (Address) 1030 W. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
W. W. Laboyteaux	7/7/24
20-UNDERTAKER. David Carlson	ADDRESS 98 Penn

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 88367 HEALTH DEPARTMENT—CITY OF BALTIMORE D/88367

CERTIFICATE OF DEATH.

77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Grantly. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Raff.

(a) RESIDENCE NO. 722 Grantly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? --- yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Sept 16, 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk, American

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale

(c) Name of employer Corporation.

9 BIRTHPLACE (city or town) (State or country) Harrisburg, Pa.

PARENTS

10 NAME OF FATHER Jacob Raff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Neuberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Lydia Barnes (sister)

(Address) 722 Grantly St.

15 Filed ....., 19.....

JUL 5 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to July 3, 1924.

that I last saw her alive on July 3, 1924,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Dementia.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypostatic congestion of the Lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M Reinhardt, M. D.

(Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sheb Shalom Cem	July 6 1924
20 UNDERTAKER	ADDRESS
J Ahrens Co	1611 Mad Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88368

CERTIFICATE OF DEATH.

D 88368

1-PLACE OF DEATH

City of BALTIMORE: (No. 1260 Battery Ave St., 24 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Summers

(a) Residence No. 1260 Battery Ave St., ... Ward, ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Zipporah Summers

6-DATE OF BIRTH (month, day and year) Jan 15 1848

7-AGE, 76 yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Crisfield Maryland

PARENTS.

10-NAME OF FATHER, Samuel Summers

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Crisfield Maryland

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14- (Informant) Mrs Zipporah Summers

(Address) 1260 Battery Ave

15- Filed ..... 192 ..... Registrar.

JUL 5 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2 1924

17- I HEREBY CERTIFY, That I attended deceased from May 28 19 24 to July 2 19 24

that I last saw him alive on July 1 19 24

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Vulvular Heart Disease

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) W. D. Smith M. D.

July 3 1924 (Address) 109 W. Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL, July 5, 1924

20-UNDERTAKER. John H Deems — ADDRESS 715 Light St

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88369

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Aisquith ST., 9 WARD)

2-FULL NAME James B. Watkins

(a) RESIDENCE No 1424 Aisquith ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexina Magness Watkins

6 DATE OF BIRTH (month, day, and year) April 1 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Nicholas Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Eugenia Brainard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Maryland

14 Informant Walter B. Watkins
(Address) 1424 Aisquith St.

15 Filed JUL 5 - 1924 GL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/16 —, 1924, to 7/3 —, 1924.

that I last saw him alive on 7/3 —, 1924.

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows: Hemiplegia Left side

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac arthma

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Burgess, M. D.

, 19 (Address) 1928 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 7 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor-

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88370

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 622 George St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. Carroll

(a) Residence No. 622 George St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widr

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lethonia Carroll

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 49 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance Coll

(b) General nature of industry, business, or establishment in which employed (or employer) collector

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, W. M. Carroll

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Caroline Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) W. M. Carroll

(Address) 1329 Calhoun St

15- JUL 5 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4/24

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 4, 1924, that I last saw him alive on July 3, 1924, and that death occurred, on the date stated above, at 5.07 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clin. exam.

(Signed) Frank E. Wagner M. D.

7/4, 1924 (Address) 1056 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL, July 7, 1924

20-UNDERTAKER. John H. Toadvine — ADDRESS 142 Wash St

Instructions: Fill in all items accurately and exactly. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88371

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged men & women's Home ST., 14 WARD)

2-FULL NAME Charlotte Carter

(a) RESIDENCE NO. 1622 Druid Hill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Emma Scarlett

(Address) 1622 Druid Hill Ave

15 Filed JUL 5 - 1924 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1924, to July 3, 1924, that I last saw h alive on July 3, 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hypostasy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edward J. Wheatley, M. D.

7/5, 1924 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 5 19 24
20 UNDERTAKER John W. Toadvine	ADDRESS 1412 E. 4th

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88372 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88-003

D 88372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Stuart Memorial Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Morgan

(a) RESIDENCE NO. 823 Hartford ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie Morgan

6 DATE OF BIRTH (month, day, and year) May 2 - 99

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Co Md

PARENTS

10 NAME OF FATHER Philip Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Morgan

(Address) 823 Hartford Ave

Filed JUL 5 - 1924

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture base of skull

Auto accident (accidental)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) John H Bowers, M. D.
(Coroner.)

July 5, 1924 (Address) 1032 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Belle S. Mary's	July 5 1924

20 UNDERTAKER Sam'l H. Grace Son ADDRESS 1400 Mosher

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88373

CERTIFICATE OF DEATH.

3/ D 88373

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 Ashland Ave (St.) 10 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Nelson

(a) RESIDENCE No. 1413 Ashland Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Cd.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May. 24 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James Nelson

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Md.

12 MAIDEN NAME OF MOTHER Katie Bowie

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Katie Nelson
(Address) 1413 Ashland Ave.

15 JUL 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 24 1923 to July 1 1924.

that I last saw h[illegible] alive on June 24 1924.

and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
about a year
(duration) y. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
a few months
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Emmafield Bligh M. D.

19 (Address) 1 W. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	July 5. 1924

20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88374

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 McElderry ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Hockings

(a) RESIDENCE NO. 2212 McElderry ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of John W. Hockings

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
approx	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md.

PARENTS

10 NAME OF FATHER Harry Dockens

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John W. Hockings (Address) 2212 McElderry (Hockings)

15 Filed JUL 5 - 1924 by ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to July 1, 1924.

that I last saw h e alive on June 30, 1924,

and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis interstitial with Hypertension

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

7/2, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	July 6 1924
20 UNDERTAKER Milton Davis	ADDRESS 315 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88375 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1460 88375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hosp. St.: 13 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agatha L White

(a) RESIDENCE. No. 3307 Beech Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Ernest R White

6 DATE OF BIRTH (month, day, and year) Nov 12 1904

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
19	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Balto

PARENTS

10 NAME OF FATHER Michael J Minton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash D C

12 MAIDEN NAME OF MOTHER Catherine Cressa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Michael J Minton
(Address) 3343 Chestnut ave

15 Filed ....., 19..... Registrar

JUL 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to July 4, 1924, that I last saw her alive on July 3, 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pyelitis Chronic

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 3307 Beech ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physicians

(Signed) Wm F Finnegan, M. D.

19 (Address) 2631 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 7 1924

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33rd St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. A.

Spec.—1-10-21—M&T—1500 Bks.

(Corbin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88376

CERTIFICATE OF DEATH.

D 88376

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp (St.) 22 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosely Corbin

(a) RESIDENCE NO. Hillsdale Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alverdia E Corbin

6 DATE OF BIRTH (month, day, and year) March 29 1868

7 AGE Years 56 Months 3 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer D. Snyder 075

9 BIRTHPLACE (city or town) (State or country) Md. Towson

PARENTS

10 NAME OF FATHER Joshua Corbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Rosely Corbin

(Address) Hillsdale Md

15 Filed JUL 5 1924 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 3. 24

17

I HEREBY CERTIFY, That I attended deceased from 7. 1. 24, 19 ... to 7. 3. 24 19 ...

that I last saw him alive on 7. 3. 24 ..., 19 ...

and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Liver

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical Signs

(Signed) Geo Adamson Corbin, M. D.

, 19 (Address) Md Gen Hospt,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Woodlawn Cemt July 7 1924

20 UNDERTAKER — ADDRESS

William Sackett Northam

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS STATEMENT IS A PERMANENT RECORD.

COPY

...ALTH DEPARTMENT—CITY OF BALTIMORE

D 88377

CERTIFICATE OF DEATH.

4/6 D 88377

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Pierce ST., 18 WARD)

2-FULL NAME Rachel Perkins

(a) RESIDENCE NO. 830 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Joseph Perkins

6 DATE OF BIRTH (month, day, and year): -- -- 1859

7 AGE: Years 65; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Kent Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Addie Dilogy (Address) 830 Pierce St.

15 JUL 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to July 1, 1924

that I last saw her alive on June 24, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

Following Senile Gangrene (Duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. F. Rowell, M. D.

July 7, 1924 (Address) 119 Karrow Ave City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: July 5 1924

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88378

CERTIFICATE OF DEATH.

31 D 88378

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 W 34th St St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Covahey

(a) Residence No. 717 W 34 St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 12 1898

7-AGE. 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Out House

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). md

PARENTS.

10-NAME OF FATHER. John F Covahey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER. Mary B McKnell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Mary B Covahey

(Address) 717 W 34 St

15- Filed..... 19?..... Registrar.

JUL 5 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1923 to July 3rd 1924

That I last saw him alive on July 2nd 1924

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 11 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray & sputum exam.

(Signed) [illegible] M. D

7/4, 1924 (Address) 3429 Chestnut St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. July 7 1924

20-UNDERTAKER. CHENOWETH & SON. ADDRESS 3617 CHESTNUT AVE.

In plain terms, so that it may be properly classified. State EXACTLY. PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88379

D 88379

CERTIFICATE OF DEATH.

16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Rosier

(a) RESIDENCE NO. 2637 Bernard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 7/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard W Rosier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard W Rosier (Address)

15 Filed JUL 5 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

Autopsy at Hopkins

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J S Mallon, M. D. (Coroner.)

July 5, 1924 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wm Rudal	July 6 1924

20 UNDERTAKER SHERWOOD & SON ADDRESS 2512 CHESTNUT AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88380

D 88380

148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (ST.,) 13 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Jacobson.

(a) RESIDENCE NO. 3963 Roland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

3a If married, widowed, or divorced HUSBAND of (~~or~~) WIFE of Philip Jacobson.

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 NAME OF MOTHER Rosa Bollinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Philip Jacobson (Address) Balto, Md.

15 Filed JUL 5 1924, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5-1924

17

I HEREBY CERTIFY, That I attended deceased from 7-4-, 1924, to 7-5-, 1924, that I last saw her alive on 7-5-, 1924, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Eclampsia, puerperal.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-4-24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	July 8 1924

20 UNDERTAKER GRENOWETH & SON ADDRESS 307 CHESTNUT ST. 3 P m

malion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88381

CERTIFICATE OF DEATH.

44 D 88381

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Mann

(a) RESIDENCE. No. 3220 Westwood St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Mann

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 45

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Robert Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Jennie Stillwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Municipal Hospital Records
(Address)

15 Filed [illegible] 19 GLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 1924, to 7-2, 1924

that I last saw him alive on 7-2, 1924

and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude T. Bruce M. D.

7-1 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 7 1924

20 UNDERTAKER GRENOWETH & SON ADDRESS 3617 CHESTNUT AVE

3

WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—B.B.P.S.—400 Pds.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83382

CERTIFICATE OF DEATH.

44 D 83382

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 321 N Carey St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hillcain Luthicum Fetchen

(a) Residence No. 321 N Carey St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 1/1851

7-AGE, 73 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gilder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.A. Co Md

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER Thos. Church. Fetchen.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Eng Conn

12-MAIDEN NAME OF MOTHER, Annis Luthicum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), U.A.C. Md

14- (Informant) Mrs Lillian Fetchen Fleet

(Address) 321 N Carey st

15- JUL 5 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4/1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to July 4 1924

that I last saw him alive on July 4 1924

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Incarceration Gut

Cardiac Weakness. (Duration) (2 da) yrs. mos 30 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan M. D.

, 19 (Address) 1322 Hanover av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July, 1924
20-UNDERTAKER.	ADDRESS
George J. Smith	1532 Hollins st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88383

CERTIFICATE OF DEATH.

12 D 88383

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 536 E 23rd ST.; 9 WARD)

2-FULL NAME William J. Lowman Jr.

(a) RESIDENCE. No. 536 E 23rd St. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 18 1909.

7 AGE: Years: 15 Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm. J. Lowman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Fannie Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Wm. Lowman
(Address) 536 E 23rd St

15 Filed JUL 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1924

I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to July 3, 1924 that I last saw h[im] alive on July 3, 1924 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Streptococcemia

(duration) yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hepatitis Tabetiformis

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Richardson M. D.

(Address) 117 W. 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 7 1924

20 UNDERTAKER: E. A. Wedefield — ADDRESS: 501 E 22 St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 88384

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 88384

REGISTERED NO.

CITY OF BALTIMORE: (No. 2821 Presstman ST.; 16th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Leonora Bishop

(a) RESIDENCE. No. 2821 Presstman ST., 16th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (Deceased) Wm. J. E. Bishop

6 DATE OF BIRTH (month, day, and year) July 23, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va

PARENTS

10 NAME OF FATHER Wm. Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mathews Co. Va

12 MAIDEN NAME OF MOTHER Mary Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Princess Anne, Va

14 Informant Chas. E. Bishop

(Address) 2821 Presstman St

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1924 to July 4th, 1924

that I last saw her alive on July 4th, 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility; Toxic hypertension

(duration) 20 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests.

(Signed) D. Edgar Fan, M. D.

7/4. 1924 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va.	7/5 1924
20 UNDERTAKER J. J. Raney & Sons	ADDRESS 318 Eighth St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Uri Kilbourn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88385

CERTIFICATE OF DEATH.

186-003

D 88385

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Home Infirmary & Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instesd of street and number and fill out No. 18.)

2-FULL NAME Uri Kilbourn

(a) RESIDENCE No. 39 Southern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Kilbourn

6 DATE OF BIRTH (month, day, and year) 3/19/1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Summit Co. Ohio

PARENTS

10 NAME OF FATHER Luther Kilbourn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant John Kilbourn
(Address) 39 Southern Ave.

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Auto Accident

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison M. D.
(Coroner.)

July 7, 1924 (Address) 1192 Poland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 7/7/ 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Every item of information is very important, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88386

CERTIFICATE OF DEATH.

1924 57 D 88386

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2556 W. Pratt St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Minnie Stocker

(a) Residence No. 2556 W. Pratt St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Stocker

6-DATE OF BIRTH (month, day and year)

7-AGE. 69 yrs. 11 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home work

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, John Grube

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Hahnmann

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-INFORMANT. William Stocker

(Address) 2556 W. Pratt st.

15- JUL 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 1916 to July 4 1924, that I last saw h.r alive on July 4 1916, and that death occurred, on the date stated above, at Am. P. m. The CAUSE OF DEATH* was as follows:

Dementia Cerebralis

Hypertensia Cerebrovascularis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Anasarca

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard A. Kelly M. D

, 19 (Address) 1706 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. July 7 19 24

20-UNDERTAKER. O. Schloman ADDRESS 1031 Hanover ave

In plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80

D 88387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Laber

(a) RESIDENCE. No. 216 S Bruce ST., 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER August Laber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Schafstein

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Dora Laber
(Address) 216 S Bruce St

15 JUL 6 - 1924 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1924

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 19 24 to July 5th, 19 24
that I last saw him alive on July 5th, 19 24
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions
Possibly intestinal origin?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy McCleary, M. D.
July 7, 19 24 (Address) 706 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 7 1924

20 UNDERTAKER ADDRESS

Mr. Mrs A S Fink 1737 W Pratt St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated AT LAST BIRTHDAY.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88388

CERTIFICATE OF DEATH.

113 D 88388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2636 E. Oliver ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen E. Harp

(a) RESIDENCE No 2636 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PLEASE ANSWER QUESTIONS EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) May 8/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. S. Harp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Miriam Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Wm. S. Harp (Address) 2636 E. Oliver St

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/24[92]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Waller, M. D.
(Coroner.)

7/6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

UNDERTAKER Zirkler & Zirkler

DATE OF BURIAL July 7, 1924

ADDRESS 1739 Eager

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88389 CERTIFICATE OF DEATH. 178 D 88389

1-PLACE OF DEATH Off Cove Point,
CITY OF BALTIMORE: (No. Chesapeake Bay. ST., 5 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Parker.(C)

(a) RESIDENCE NO 1537 E.Fayette St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Henry Parker(C)

6 DATE OF BIRTH (month, day, and year) June 16, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Louis Thompson.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Pryor.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Mila Rich.(C) sister.
(Address) 1537 E.Fayette St

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inyestigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Drowning, Jumped into the water from the burning steamer "Three Rivers" Accidental Death

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northumberland Co. Va. DATE OF BURIAL July 6 1924

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725 Ashland Ave

DEATHS OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88390

3/17

D 88390

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Quinton Lopez

(a) Residence No. 921 Middle Court St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ester Lopez

6-DATE OF BIRTH (month, day and year) 1903

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

640

9-BIRTHPLACE (city or town) (State or Country), Portugal

PARENTS.

10-NAME OF FATHER, John Lopez

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Portugal

12-MAIDEN NAME OF MOTHER, Georgette Everett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Portugal

14- (Informant) Hospital Records

(Address) M.T.H.

JUL 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 11, 1924 to July 3, 1924

that I last saw h. im alive on July 3, 1924

and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Cerebral Adenitis

Acute Miliary T.B.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab. findings - Autopsy.

(Signed) J. A. Waller M. D.

7-3- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Sacred Heart Cem	July 7, 1924
20-UNDERTAKER.	ADDRESS
Wm R A Elliott	1125 Oakland Ave

Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88391

CERTIFICATE OF DEATH.

D 88391

1-PLACE OF DEATH

City of BALTIMORE: (No. 5306 Park Heights Ave. Ward) 27

Registered No. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... William Ohm

(a) Residence No... 5306 Park Heights Ave. Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes V. Ohm

6-DATE OF BIRTH (month, day and year) Sept 28 1855

7-AGE. 68 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Dinner

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Philip Ohm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs Agnes V. Ohm

(Address) 5306 Park Heights Ave

JUL 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3 1924

17- I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to July 3, 1924, that I last saw him alive on July 3rd, 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy followed by Paralysis

(Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) Organic Heart Kidneys (Duration) ...yrs. 6 mos. 3 ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hoffman M. D.

July 5, 1924 (Address) 1809 Bolton St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemy	July 7, 1924
20-UNDERTAKER. Jos Jos Adams Son	ADDRESS 2173 Boa

Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88392 — 1-PLACE OF DEATH

44 D 88392 — Registered No.....

City of BALTIMORE: (No. 719 Glenwood Ave (St.) 27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Charles. ch. Small

(a) Residence No. 719 Glenwood Ave (St.) ..... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Elizabeth S. Small

6-DATE OF BIRTH (month, day and year): May 25th 1880

7-AGE: 44 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): Business for Self
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Talbot Co Md

PARENTS.

10-NAME OF FATHER: John A. Small

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Talbot Co Md

12-MAIDEN NAME OF MOTHER: Catherine E. Leonard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Talbot Co Md

14-
(Informant): Mrs Elizabeth S. Small
(Address): 719 Glenwood Ave

15-
JUL 5 - 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to July 5 1924
(but I last saw h.. alive on July 3 1924)
and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach, liver, Spleen, omentum

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary): Carcinomatosis of Viscera

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? Yes Date of March 3 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bixby, M. D

July 8 1924 (Address) 501 Sheridan Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: July 7 1924

20-UNDERTAKER: Jos Joerdens Son — ADDRESS: 2173 Pace.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88393 . HEALTH DEPARTMENT--CITY OF BALTIMORE D 88393 .

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 12

CITY OF BALTIMORE (No. 1173 Brentwood Rd 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine J. Oates

(Residence in Baltimore: No. 1123 N. Brentwood St.; 49 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: — (Month) — (Day) 1875 (Year)

7-AGE: 39 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Newsp. 087
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Freeman

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. L. Oates

(Address) 1173 Brentwood

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 3 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1923, to July 3, 1924, that I saw her alive on July 3rd, 1924, and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 8 mos. ds

Contributory (SECONDARY) Myocarditis

(Duration) yrs. mos. 7 ds.

(Signed) Fred O. Smith M. D.

July 5, 1924 (Address) 11 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Fairview Cem — DATE OF BURIAL: 7/7, 1924

20-UNDERTAKER: J. J. Lakey & Son — ADDRESS: 1314 Light St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 88394 HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D 88394

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 DeCalvin ST., 24 WARD)

2-FULL NAME Christopher Gayo

(a) RESIDENCE NO. 1421 DeCalvin ST., — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? 19 yrs. 3 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Johann

6 DATE OF BIRTH (month, day, and year) Aug. 14 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Nicholas Gayo

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER George Gayo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Elizabeth Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mr & Mrs Brady

(Address) 1424 DeCalvin St

15 Filed JUL 6 - 1924 ROBERT R. KNAUT, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I attended deceased from October, 1923, to July 3, 1924, that I last saw him alive on July 3, 1924, and that death occurred, on the date stated above, at 5-15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. S. Kurr, M. D.

7-4, 1924 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral (Cem.)	July 7. 1924
20 UNDERTAKER Chas. L. Glenn	ADDRESS 1501 E. Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88395

CERTIFICATE OF DEATH.

90 D 88395

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 3905 Parkheights Ave ST., 15 WARD)

2-FULL NAME Wm S. Cassell

(a) RESIDENCE No. 3905 Parkheights Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or ~~WIFE~~ of) Louisa A Cassell

6 DATE OF BIRTH (month, day, and year) Sept 22, 1855

7 AGE — Years: 68 | Months: 10 | Days: 12 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 130
(c) Name of employer: U. S. Government

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm. H. Cassell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Forrest

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Louis A. Hilbert
(Address) 3905 Park Heights Ave

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison, M. D.
(Coroner.)

July 5, 1924 (Address) 303 N. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Mt Olivet — DATE OF BURIAL: July 7 1924

20 UNDERTAKER: Geo W Little — ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001
100 D 88396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Inf. ST., 6 WARD)

2-FULL NAME Miss Sarah M Howard.

(a) RESIDENCE NO. Church Home & Inf. ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/6/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	yrs		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundell Co.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Allen B. Howard
(Address) Annapolis Md

15 Filed JUL 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 24

17 I HEREBY CERTIFY, That I attended deceased from July 4, 19 24, to July 6, 19 24.
that I last saw h[illegible] alive on 7/6, 19 24
and that death occurred, on the date stated above, at 7:40 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Bronchopneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Chester Fanelton, M. D.

, 19 (Address) Church Home Inf Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL July 7 1924

20 UNDERTAKER Jas J. Taylor Sons — ADDRESS Annapolis Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88397

CERTIFICATE OF DEATH.

44 D 88397

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Mary Russell

(a) RESIDENCE NO. 228 N. High ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthew Russell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address) Hebrew Hospital

15 ROBERT R. KRAUTER, Burial Permit Registrar

JUL 6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1924, to July 5, 1924.

That I last saw her alive on July 5, 1924.

And that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

CONTRIBUTORY (Secondary) Sarcoma of rt. femur & pelvic bones (duration) yrs. mos 3 ds.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Isidore D. Fry M. D.

July 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery

DATE OF BURIAL 7/7 1924

20 UNDERTAKER Chas. P. Evans & Son

ADDRESS 1180 W. Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88398

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. 88398

City of BALTIMORE: (No. 1103 W. Lanvale St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Jones

(a) Residence No. 1103 W. Lanvale St. St., Ward.

(Usual place of abode) Lifetime (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy E. Jones.

6-DATE OF BIRTH (month, day and year) Aug. 29/1852.

7-AGE. 71 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Bank Paying Teller.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER David Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER Catherine A. Watkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington D.C.

11- (Informant) Lucy E. Jones

(Address) 1103 W. Lanvale St.

15- JUL 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 3/1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17 1924 to July 3 1924, that I last saw him alive on July 3 1924 and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Radiographic and Burial signs

(Signed) Charles Lee M. D.

July 4th, 1924 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery.	July 7 1924.
20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal Ave.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.—400 Eks.

D 88399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001

Registered No. D 88399

1-PLACE OF DEATH

City of BALTIMORE: (No. 632 Linwood Ave Roland Park St., 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. William H Winternitz

(a) Residence No. 632 Linwood Ave. Rol Pk St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Winternitz

6-DATE OF BIRTH (month, day and year) Nov. 22/1846

7-AGE. 77 yrs. 7 mos. 13 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Charles Winternitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Nil[illegible]a Bloch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria.

11- (Informant) Mrs. Stadtmuller

(Address) 632 Linwood Ave.

15- Filed JULY 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 5-1924

17- I HEREBY CERTIFY, That I attended deceased from June 28th, 1924 to July 5th, 1924 that I last saw him alive on July 4th, 1924 and that death occurred, on the date stated above, at 6 50 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None needed

(Signed) Wm. A. Clarke M. D.

, 19 (Address) 151 Johns Road-Roland Park

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Har Sinai Cem. DATE OF BURIAL. July 7th 1924

20-UNDERTAKER. Harry Sondheim ADDRESS 1184 W Royal Av

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 38400 HEALTH DEPARTMENT—CITY OF BALTIMORE D 38400

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. St. Mary's Ind. School Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brother Dennis Hayden

(a) Residence No. St. Mary's Ind School Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE: 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Brother
(b) General nature of Industry, business, or establishment in which employed (or employer): St. Mary's Ind School
(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Kentuckey

PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant): Bro. Paul
(Address): St. Mary's Ind School

15- Filed ..... 192.....

JUL 7 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 5 - 1924

17- I HEREBY CERTIFY, That I attended deceased from 6/4 19 24 to 7/5 19 24

that I last saw h[illegible] alive on 7/5 19 24

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis &
Chronic Endocarditis Nephritis
cuts general edema Anasarca

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. S. Deaver M. D

19 24 (Address) 804 Cathedral St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 7/7 19 24

20-UNDERTAKER: Chas. P. Crane & Son — ADDRESS: 18 W. Mt. Royal Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

D 88401

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 88401

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Baker ST., 15 WARD)

2-FULL NAME Eugene Brown

(a) RESIDENCE No. 614 Baker St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irma Brown

6 DATE OF BIRTH (month, day, and year) About 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Day
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's, Md.

PARENTS

10 NAME OF FATHER Phillip Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Irma Brown
(Address) 614 Baker St.

15 Filed JUL 7 - 1924 GB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of aneurism (aorta)

(duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy, M. D.
(Coroner.)

July 7, 1924 (Address) 2502 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Grave	July 9 1924
20 UNDERTAKER	ADDRESS
Jesse Pedan	434 Bell St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88402

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 672 Washington Blvd (St.) 72 (WARD)

2-FULL NAME Lue B. Meushaw

(a) RESIDENCE No. 672 Washington Blvd St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary. C Meushaw

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Corset Maker.
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer Suchling & Bros.

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Thos Meushaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Catherine Fitzgerald.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary. A Meushaw
(Address) 672 Washington Blvd.

15 Filed JUL 7 192- 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident
Contusion & Lacerations
R- Head

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

(Signed) Geo Edw Wade M. D.
(Coroner)

July 6 192 (Address) 1715 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md.

DATE OF BURIAL 7-7 1924

20 UNDERTAKER James Dignan & Son. ADDRESS 1200 E Pleasant St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88403

CERTIFICATE OF DEATH.

179 D 88403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mir Hospital ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Fritz

(a) RESIDENCE NO 669 Colombia ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 8-1923 Inquest

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Milton Fritz

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Dorsey or Seymour

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Hospital Record
(Address) — —

15 Filed ..... 192 ..... Registrar

JUL 7 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Burn Resulting in Infections.

(duration) 2 weeks yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. Clinton Black, M. D.
(Coroner)

July 6th 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 7-7 1924

20 UNDERTAKER James Dignan & Son — ADDRESS 100 E Baal St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88404

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2324 Calverton Heights Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Simpson Baker.

(a) Residence No. 2324 Calverton Heights Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ WIFE of John G. Baker

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 50 yrs. ..... mos. ..... ds. Calculated from insurance policies

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Rezin N. Pumphrey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Rebecca Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C.

14- (Informant) Hale C. Stansbury

(Address) 1037 Edmondson Ave.

15- JUL 7 - 1924 G.G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4, 1924

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to July 4, 1924, that I last saw her alive on July 4, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma.

(Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous nephritis (Duration) 0 yrs. 10 mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Urinary analyses.

(Signed) John G. Stansbury M. D.

7/4, 1924 (Address) 1037 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	July 9th 1924
20-UNDERTAKER	ADDRESS
Josiah Lyffe	1600 W North Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 88405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1113

D 88405

1-PLACE OF DEATH On way to United States REGISTERED NO.

CITY OF BALTIMORE: (No. 1422 Carroll ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Dilser

(a) RESIDENCE NO. 1422 Carroll ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-10-24

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ... min.
	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of Industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Dilser.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Ehrest.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant ....

(Address) ....

15 Filed JUL 7 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to July 3 1924

that I last saw him alive on July 3, 1924

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Dyspepsia Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? ... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) M Lloyd Dorsey M. D.

, 19 (Address) 1717 West Bel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL July 7 1924

20 UNDERTAKER Edward F Cowan & Son

ADDRESS 901 Hollins St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-B 88406

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Ferguson

(a) RESIDENCE NO. 1226 McCulloh ST., St. WARD m.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Ferguson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JUL 7 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 19 24

17

I HEREBY CERTIFY, That I attended deceased from June 11, 19 24 to July 4 19 24

that I last saw him alive on July 4 19 24

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Interviscerite Gangrene of foot (lt).

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? x x

Did an operation precede death? Yes. Date of June 15, 1924

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Bradley M. D.

, 19 (Address) J. H. Hospital C.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 8 1924
20 UNDERTAKER John W Henderson	ADDRESS 1502 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88407

CERTIFICATE OF DEATH.

1117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hos. ST.; 27 WARD)

2-FULL NAME Mrs Matte Godman

(a) RESIDENCE NO. 6 Krebs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Clarke Godman

6 DATE OF BIRTH (month, day, and year) Nov 9 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	44	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Tilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Feathers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rev. Clarke Godman

(Address) 6 Krebs Ave

15 Filed ....19.... Registrar

JUL 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to July 4, 1924, that I last saw her alive on July 4, 1924, and that death occurred, on the date stated above, at 8.30P m.

The CAUSE OF DEATH* was as follows:

Peritonitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1 1924

Was there an autopsy? no

What test confirmed diagnosis? Appendix.

(Signed) F. S. Robertson, M. D.

, 19 (Address) 350 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July 7 1924

20 UNDERTAKER Wm J Pickner & Sons ADDRESS North & Pa

MARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88408

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3007 N. Calvert ST., 17 WARD)

2-FULL NAME M. Virginia Esselmann

(a) RESIDENCE NO. 3007 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Wes. Esselmann

6 DATE OF BIRTH (month, day, and year) Aug 3, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Christ

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs. Lillian Winbigler
(Address) 3007 N. Calvert St

15 JUL 7 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Thos. Morrissey, M. D.
(Coroner.)

July 6, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL July 7 1924

20 UNDERTAKER Wm. Tickner & Sons ADDRESS North Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 38409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3603 Clifton Ave St., 15 Ward)

Registered No. 15159-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Arthur Dale Murphy

(a) Residence No. 3603 Clifton Ave St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Nov 3 1923

7-AGE. 8 yrs. 8 mos. 2 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. H Talmor Murphy

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Lucia Granam

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-Informant. Mrs E. Murphy

(Address) 3603 Clifton

15-

JUL 7 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July-5-24

I HEREBY CERTIFY, That I attended deceased from Nov. 3 1923 to July-5 1924

that I last saw him alive on July 4 1924

and that death occurred, on the date stated above, at 10-a. m.

The CAUSE OF DEATH was as follows:

Spina Bifida - with operation and resultant hydrocephalus

(Duration) yrs. 8 mos. 2 ds.

CONTRIBUTORY (Secondary) General asthenia and ultra cranial pressure

17-If a woman, was pregnancy a factor? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Obs.

(Signed) Wesley Cole, M. D

7/5, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Southern Cemetery

DATE OF BURIAL. July 7, 1924

20-UNDERTAKER. Martin Funeral Home

ADDRESS 1837 N. North.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Cause of death should be stated EXACTLY. PHYSICIANS

Cor.—1-12-23—M&T—100 Bks.

D 88410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88410

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 10th St nr Eager ST., 26 WARD)

2-FULL NAME John R. Rattman

(a) RESIDENCE No 10th St nr Eager Orangeville WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Rattman

6 DATE OF BIRTH (month, day, and year) Feb 2/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	3 2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of Industry, business, or establishment in which employed (or employer) Delion Tire Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Rattman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Ruhman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lena Leimkuhler
(Address) ~~10th St Eager~~

15 Filed JUL 7 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency- Chronic Nephritis (Uremia)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S T Collins, M. D.
(Coroner.)

July 7 192 4 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	July 8 192 4
20 UNDERTAKER Mrs Christian Mull	ADDRESS 2334 Jefferson

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- it may be properly classified, so that PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 8841F

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 8841F

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 E. Eager ST. 10 WARD)

2-FULL NAME Mary R. Kaufman

(a) RESIDENCE. No. 1101 E Eager ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Ehrnicke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Kaufman
(Address) 1101 E. Eager St

15 Filed JUL 7 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1 1924 to July 5 1924

that I last saw her alive on July 4 1924

and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Arens, M. D.

(Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	July 8th 1924

20 UNDERTAKER Johannah Landes ADDRESS 1004 Fairmount Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88412

CERTIFICATE OF DEATH.

11 D 88412

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1035 Harford Ave St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) Residence No. 1035 Harford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds Now long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alex. Johnson, deceased

6-DATE OF BIRTH (month, day and year) Aug 20 - 1845

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany -

PARENTS.

10-NAME OF FATHER, ? Schmuck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Pauline Jacoby -

(Address) 1035 Harford Ave -

15- Filed JUL 7 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 5 - 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 28, 19 24 to July 5, 19 24

that I last saw h[illegible] alive on July 4, 19 24

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Gastro - enteritis.

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia - Decompensated heart -

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) George Abner Bausler M. D.

7/5, 1924 (Address) 1517 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md. DATE OF BURIAL, 7 - 7, 1924

20-UNDERTAKER E & B Hasle 115 ADDRESS E West St.

Instructions: Items must be answered in full, so far as known. Supplies. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Antonina Rawa

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88413 — 89 — D 88413

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5'29 S Ann St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonina Rawa

(Residence in Baltimore: No. 6'29 S. Ann St.; yrs., 20 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Albert Rozmiski

11-BIRTHPLACE OF FATHER, (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER, (State or Country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antony Rawa

(Address) 629 S. Ann St

15- JUL 7 - 1924 [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina Pectoris

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Ruben M. D. (Coroner.)

July 6 1924 (Address) 701 E. Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	July 8th 1924
20-UNDERTAKER, W. F. Sadowski	ADDRESS 905 S. Ann St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec. 21-10-21—M&T—1500 Bks.

D 88414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88414

REGISTERED NO. 90

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 25 WARD)

2-FULL NAME Gustave Brancklioff

(a) RESIDENCE NO. 13 Locust St. ST., ... WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Brancklioff

6 DATE OF BIRTH (month, day, and year) Apr 27 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	2	9?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer Self

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Gustave Brancklioff Sr.

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Clara Brancklioff

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 7 - 1924, 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to July 6, 1924, that I last saw him alive on July 6, 1924, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 0 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) Lawrence McKeehan, M. D.

, 19 (Address) Johns Hopkin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 9 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-2t—E.B.R.S.—400 Blks.

D 88415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88415

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3726 E. Lombard St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Roemer

(a) Residence No. 3726 E. Lombard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Roemer

6-DATE OF BIRTH (month, day and year): May 15 63

7-AGE: 61 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: John Knarr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Chas. Roemer

(Address) 3726 E. Lombard St.

15-

Filed JUL 7 - 1924 19..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 6/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 19 24 to July 6 19 24

that I last saw h... alive on ... 19...

and that death occurred, on the date stated above, at 6-57 P. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(Duration) X yrs. 3 mos. X ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (Duration) X yrs. 6 mos. X ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jas. L. Kruger M. D

July 7 19 24 (Address) 2480 30 St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, 7/9 1924

20-UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 88416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88416

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2116 Glenwood Ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Barth Valentine

(a) Residence No. 2116 Glenwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Valentine

6-DATE OF BIRTH (month, day and year) January 30 1867

7-AGE. 57 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Reading Penna

PARENTS.

10-NAME OF FATHER, John Barth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baviera

12-MAIDEN NAME OF MOTHER, Josefine Bolsler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baviera

14- (Informant) Robert Gore

(Address) Glenwood Ave & Harford Road

15- Filed JUL 7 - 1924 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6 - 24

17- I HEREBY CERTIFY, That I attended deceased from November 30 1923 to July 6 1924

that I last saw h.. alive on July 6 1924

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Lymph Sarcoma

(Duration) 3 yrs. 7 mos.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Joseph L. Valentine M. D.

JUL 6 1924 (Address) 14 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem	7-8- 24

20-UNDERTAKER, Frank V. Pistorius — ADDRESS 1800 E. 32nd St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH should state DISEASE causing death, or violence producing death. Name of disease must be stated EXACTLY. PHYSICIANS should

Spec.—1-10-21—M&T—1500 Bks.

D 88417 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88417

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genl. Hosp. ST., 28 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertie R Strauss

(a) RESIDENCE NO. Kernan Hosp, Hillsdale ST. Md. WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas R. Strauss

6 DATE OF BIRTH (month, day, and year) Sept 17 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodlawn, Balto. Co Md.

PARENTS

10 NAME OF FATHER Fred Kirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Mollie E. Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Mrs. Bertie Strauss
(Address) Kernan Hosp. - Hillsdale, Md.

Filed JUL 7 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/24 19

17 I HEREBY CERTIFY, That I attended deceased from 7/1/24 .19.. to 7/6/24 .19.., that I last saw h alive on 7/6/24 .19.., and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Squamous cell carcinoma of cervix uteri.

(duration) yrs. 4? mos ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis with acute exacerbation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 7/3/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical + laboratory

(Signed) Jno A Strauss M. D.

7/6, 1924 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bat Olive (Roslyn Rd) DATE OF BURIAL July 8 1924

20 UNDERTAKER Jos K Clark ADDRESS W 3 M Balto St

mation should be carefully supplied. Add
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See Instructions on back

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88418 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88418

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 539 Longwood Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Ackerman

(a) Residence No. 539 Longwood Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary F. Ackerman

6-DATE OF BIRTH (month, day and year) Aug. 12, 1864

7-AGE.	If LESS than 1 day.
59 yrs. 10 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fuller (Dickeys)

(b) General nature of industry, business, or establishment in which employed (or employer): Woolen Mills

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore County Maryland

PARENTS.

10-NAME OF FATHER: Charles Nicholas Ackerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Caroline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs. Mary F. Ackerman

(Address): 539 Longwood Street

JULY - 1924 Filed ..... 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 23, 19.., to July 4, 19.24.

that I last saw him alive on July 4, 19.24.

and that death occurred, on the date stated above, at 10.50P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Chronic Myocardial degeneration.

(Duration) 10 yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(Duration) ? yrs. ? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Mitchell M. D.

7-5, 1924 (Address) 2901 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19..
Lorraine Cem	July 7 24
20-UNDERTAKER, Joseph L. Cole	ADDRESS 1003 N. Bath St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88419 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88419

CERTIFICATE OF DEATH.

112

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Arc 2 St. ST., 4 WARD)

2-FULL NAME Joseph Lina Hillians

(a) RESIDENCE NO 209 Arc 2 St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co Va

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ezra Howard
(Address) 209 Arc 2 St

15 Filed JUL 7 - 1924 H. Lane Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 1 hrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. ds.

(Signed) G E Olades, M. D.
(Coroner.)

July 7-24 192 (Address) 425 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7/7 1924

20 UNDERTAKER 1806 Gross 1405 McElderry

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88420

CERTIFICATE OF DEATH.

D 88420

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2234 Bank St – St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Esther Allen –

(a) Residence No. 2234 Bank St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) July 16/1915

7-AGE. 8 yrs. 11 mos. ✓ ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) HS

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City –

PARENTS.

10-NAME OF FATHER, Charles Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary Wrightson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14- (Informant) Mary Allen [illegible]
(Address) 2234 E. Bank St.

15- JUL 7 - 1924 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4 – 24

17- I HEREBY CERTIFY, That I attended deceased from Jul – 1924, to July 4 1924, that I last saw h[illegible] alive on July 3 1924, and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor – (Cerebellar)

(Duration) yrs. 6 mos. – ds.

CONTRIBUTORY (Secondary) Bronchitis & Cystitis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [signature] M. D

, 19 (Address) 125 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL.	DATE OF BURIAL.
Baltimore Md	July 7, 1924.
20-UNDERTAKER.	ADDRESS
Randall Hupfeld Co	3[illegible] Aisquith.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

172D9 88421

CERTIFICATE OF DEATH.

38D 88421

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Odessa Harrington

(a) RESIDENCE NO. 514 S. Caroline ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Percy Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.S.

12 MAIDEN NAME OF MOTHER Georgiana Reeds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.S.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JUL 7 - 1924 1576 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 21, 1924, that I last saw h[illegible] alive on June 21, 1924 and that death occurred, on the date stated above, at 12-[illegible] m.

The CAUSE OF DEATH* was as follows:

Congenital syphilis

Sepsis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds. (?)

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. A. Reed, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL July 5 1924

20 UNDERTAKER [illegible]

ADDRESS [illegible]

207

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88422

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infr (WARD)

2-FULL NAME Baby Girl Lynch.

(a) RESIDENCE No. 809 S Potomac (WARD) Baltimore Md.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/5/24.

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph E Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Minnie R Keem.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant
(Address)

15 Filed ..... 19 .....

Registrar

JUL 7 - 1924

1580

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1924

17 I HEREBY CERTIFY, That I attended deceased from 7/5, 1924, to 7/5, 1924.

that I last saw her alive on 7/5, 1924,

and that death occurred, on the date stated above at 8:22 m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) Intrauterine Life yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Anaemia.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

•Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Gaylord Cancelliere, M. D.

, 19 Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88423

88423

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. 15 St ST., 26 WARD)

2-FULL NAME Catherine Fetz-

(a) RESIDENCE NO. 408 S. 15th ST., WARD

(Usual place of abode)

(If hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael F Fetz

6 DATE OF BIRTH (month, day, and year) July 21 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. Eyerkopfer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Duerbeck

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Michael F Fetz
(Address) 408 S. 15 St

15 JUL 7 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1 , 1924 , to July 5 , 1924 , that I last saw her alive on July 3 , 1924 , and that death occurred, on the date stated above, at 6:40 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Tuberculosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) History (duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos F G Stevens, M. D.

7/7/24 (Address) 2878 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 8 1924

20 UNDERTAKER Lilly and Zeile ADDRESS 4038 Wash St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88424

CERTIFICATE OF DEATH.

74-501

D 88424

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1802 W. Lexington ST., 14 (WARD)

2-FULL NAME John F. Wennagel

(a) RESIDENCE No. 1802 W. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maggie Wennagel

6 DATE OF BIRTH (month, day, and year) Feb 2nd 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer 059

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Frederick Wennagel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant J. Frank Wennagel
(Address) 1802 W. Lexington St.

15 JUL 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
at Once
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner)
July 6th, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ... ds. In the State ....yrs., ...mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 8 1924
20 UNDERTAKER Jos Joerdens & Son	ADDRESS 2078 Bar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S. [illegible] Bks.

Baer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88425

CERTIFICATE OF DEATH.

90

D 88425

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 E. Montgomery St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carton F. Baer

(a) Residence No. 212 E. Montgomery St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Elizabeth Baer

6-DATE OF BIRTH (month, day and year) Nov 27 1853

7-AGE. 70 yrs. 7 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman at

(b) General nature of industry, business, or establishment in which employed (or employer) Brushe Bro. 086

(c) Name of employer Light St

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Don't Know

11-BIRTHPLACE OF FATHER (city or town) Don't Know (State or Country),

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (city or town) Don't Know (State or Country),

14- (Informant) Mrs Elizabeth Baer

(Address) 212 E Montgomery St

JUL 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 29th 1924, to July 6 1924,

that I last saw h[illegible] alive on July 5th 1924,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Old Age Senility

(Duration) 1 wk yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy Probable

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) M. D.

1924 (Address) 607 N Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, July 9, 1924

20-UNDERTAKER, John F Denny — ADDRESS 715 Light St

IMPORTANT. Information Required. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88426

CERTIFICATE OF DEATH.

D 88426

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mount Hope Retreat St., 24th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Smith

(a) Residence No. Mount Hope Retreat St., 28 Ward Phila-Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Smith

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, abt 66 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gardner &

(b) General nature of Industry, business, or establishment in which employed (or employer) Gardening

(c) Name of employer.....

9-BIRTHPLACE (city or town) (?) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Francis Smith

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary A-Reilly

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), Ireland

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Retreat Balto Md

JUL 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1923, to July 7, 1924,

that I last saw h. alive on July 3, 1924,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cure L. Hemiplegia

abt (Duration) 2 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (Duration) yrs. 9 mos. 0 ds.

18-Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flanner, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL, July 7 1924

20-UNDERTAKER STEWART & BROWEN COMPANY (WILLIAM P. BROWEN, Successor)

ADDRESS [illegible]

Every item of information must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

Dr McCleary Coroner – Marlberry

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-09 D 88427

D 88427

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4807 Park Heights Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Freaner

(a) Residence No. 4807 Park Heights Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Minnie Freaner

6-DATE OF BIRTH (month, day and year): Apr 10. 1862

7-AGE: 62 yrs. 2 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED:

(a) Trade, profession, or particular kind of work: Insurance Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 87

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Frederick Md.

PARENTS.

10-NAME OF FATHER: Vincent H Freaner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Minnie Freaner

(Address) 4807 Park Heights Ave

15- Filed JUL 7 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 6. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 6 1924 to July 6 1924

that I last saw h[illegible] alive on July 6 1924

and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cirrhosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): General Edema, Ascites

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr W McCleary M. D.

(Address) 1001 Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mon Cathedral

DATE OF BURIAL: July 8, 1924

20-UNDERTAKER: J W Cook

ADDRESS 502 E Lanvale Ave.

Instructions: Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S—400 Bks.

2002 N. Luzerne

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88428

CERTIFICATE OF DEATH.

47 D 88428

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2054 Lanvale Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Estelle Frazier

(a) Residence No. 2542 Lanvale Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph H.

6-DATE OF BIRTH (month, day and year) Nov 27 1882

7-AGE. 42 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Elija Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Sara V. Rosenbush

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Joseph H. Frazier

(Address) 2542 Lanvale Ave

15- JUL 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1924 to July 6 1924 that I last saw her alive on July 6 1924, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? C

Did an operation precede death? C Date of

Was there an autopsy? C

What test confirmed diagnosis? C

7/7 1924 (Signed) Walter E. Tuckerman M. D

(Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. July 8 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 E 14th

Instructions Regarding Supplies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88429

CERTIFICATE OF DEATH.

32 D 88429

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., WARD)

2-FULL NAME Thomas Stuart

(a) RESIDENCE NO. 311 S. Ann ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ezra Vaine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Betz
(Address) 2042 Gough st

15 JUL 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1924, to July 6, 1924, that I last saw him alive on July 6, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 1 ds. 6

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? T.B. Bacillus in Spinal Fluid

(Signed) Isidore S. Levy, M. D.

July, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 8 1924

20 UNDERTAKER: Robt J Turner & Sons — ADDRESS: 1 Broadway

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

13217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88430

CERTIFICATE OF DEATH.

X 131 D 88430

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Harold Hawse

(a) RESIDENCE NO. Rockwood, W. Va. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. ? mos. ? ds. 10.?

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Boy

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John Hawse

11 BIRTHPLACE OF FATHER (city or town) W. Va. (State or country)

12 MAIDEN NAME OF MOTHER Amy Roland

13 BIRTHPLACE OF MOTHER (city or town) W. Va. (State or country)

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL.

15 JUL 7 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to July 7, 1924, that I last saw him alive on July 7, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cystopyelitis

Congenital Valves of posterior urethra

~~Duration~~ (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital Valves of Posterior urethra

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harvey G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wardenville W Va

DATE OF BURIAL July 7 1924

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 B Way

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88431

CERTIFICATE OF DEATH.

46 D 88431

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 E. Virginia Ave 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Louisa Whiteford

(a) Residence No. 222 E. Virginia Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Nicholas D Whiteford

6-DATE OF BIRTH (month, day and year) July 19 1869

7-AGE. 54 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Adam Einwachter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Louisa Earling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Mr. Chas. Whiteford

(Address) 222 E. Virginia Ave

15-Filed JUL 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6 1924

17- I HEREBY CERTIFY, That I attended deceased from June 6 19 24 to July 6 19 24

that I last saw her alive on July 6 19 24

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Lab. Specimen

(Signed) H. H. Kerr Dorsey M. D

, 19 (Address) 1207 Madison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. July 8 1924

20-UNDERTAKER. Wm Pickersgill Sons ADDRESS Norfolk Va.

Indicated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88432

CERTIFICATE OF DEATH.

70 D 88432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 622-N-Mount ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Marshall

(a) RESIDENCE NO. 622-N-Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Marshall

6 DATE OF BIRTH (month, day, and year): Sept 2, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store 040

(b) General nature of industry, business, or establishment in which employed (or employer): Confectionery

(c) Name of employer: Own

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Moran Polk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Katherine Marshall

(Address) 622-N-Mount St

Filed JUL 7 - 1924 ROBERT R. KRAUTH, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1924

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to July 5, 1924.

that I last saw h- alive on July 5, 1924.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Abscess

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Frontal Sinusitis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Dackey, M. D.

, 19 (Address) 1818 W-Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: July 8 1924

UNDERTAKER: Samuel P. Krauth

ADDRESS: 1718 E Balto

This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88433

Sp... 6-24 H. T. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 88433

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Ettting ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Spens

(a) RESIDENCE. No. 1138 Ettting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 1903

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 968

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER James Spens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Spens

(Address) 1138 Ettting St

15 JUL 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/21, 1924, to 7/5, 1924, that I last saw h[e] alive on 7/5, 1924, and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) William P Spens, M. D.

19 (Address) 1200 Penn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 8 '24

20 UNDERTAKER Edmondson Avenue ADDRESS 1301 Edmondson Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88434

CERTIFICATE OF DEATH.

38 D 88434

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2809 Parkwood Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Volker

(a) Residence No. 2809 Parkwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~single~~ Married ~~Widowed~~ ~~or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude S. Volker

6-DATE OF BIRTH (month, day and year) June 6th, 1873

7-AGE. 51 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Continental Trust Co.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Volker

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Francis

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Mrs H. J. Volker

(Address) 2809 Parkwood Ave.

JUL 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to July 7, 1924 that I last saw him alive on July 6, 1924 and that death occurred, on the date stated above, at 2.55 A. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Gaddess M. D.

July 7, 1924 (Address) 321 225 St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, July 9th, 1924

20-UNDERTAKER, Bertram Bolgiano — ADDRESS 1723 W Lafayette Ave

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88435

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Bass

(a) RESIDENCE NO. 527 Rosemwood ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md

PARENTS

10 NAME OF FATHER Edmund Bass

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Jessie Jacob.

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Ernest E. Bass

(Address) Richmond Va.

15 Filed JUL 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1924. to July 7, 1924.

that I last saw her alive on July 6, 1924,

and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsilla pharyngeal & laryngeal

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? cultures (+)

(Signed) Bella Lawson M. D.

7/7/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Va. DATE OF BURIAL July 8 1924

20 UNDERTAKER Wm. Cook & Son ADDRESS Richmond Va

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hucles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83436

CERTIFICATE OF DEATH.

90 ✓ D 88436

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Druid Hill St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel R. Hucles.

(a) RESIDENCE NO. 2024 Druid Hill St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced (or) ~~WIFE of~~ HUSBAND of Columbia Hucles

6 DATE OF BIRTH (month, day, and year) Sept. 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Hucles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Columbia Hucles

(Address) 1024 Druid Hill ~~ROBERT N. KRAUTER~~

15 Filed JUL 7 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1924 to July 6, 1924

that I last saw h— alive on July 6, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) W. T. Carr, Jr., M. D.

, 19 (Address) 615 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel County.	7/8/24
20 UNDERTAKER	ADDRESS
Helen A. Holland	1631 D St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88437

CERTIFICATE OF DEATH.

74 001

D 88437

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Ettinge St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Pipes

(a) RESIDENCE No. 1721 Ettinge St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Pipes

6 DATE OF BIRTH (month, day, and year) April 2, 188[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Alexander Pipes
(Address) 1721 Ettinge St.

15 Filed JUL 7 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

July 7, 1924 (Address) 28 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery — DATE OF BURIAL 7/9/1924

20 UNDERTAKER Geo. T. A. Gibson — ADDRESS 1730 Druid Hill ave.

CAUSE OF DEATH should be stated EXACTLY. AGE should be stated in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88438

CERTIFICATE OF DEATH.

178 D 88438

1-PLACE OF DEATH On Steamer "Three Rivers".

REGISTERED NO.....

CITY OF BALTIMORE: (No. off Cove Point, Chesapeake Bay ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon E. Jefferson.

(a) RESIDENCE NO. 511 S. Fulton Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. -- mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) June 17, 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	---	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas E. Jefferson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Spurrier.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Mary Jefferson. (mother).
(Address) 511 S. Fulton Ave.

15 Filed JUL 8 1924 GLS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers"

Accidental Death (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto C. Reinhardt M. D.
(Coroner.)

July 7th, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 8 1924
20 UNDERTAKER H. W. McCurdy Son	ADDRESS Balto. Md

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-
o that it may be properly classified. PHYSICIANS should state
in plain terms, so that

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88439

CERTIFICATE OF DEATH.

178 D 88439

1-PLACE OF DEATH On Steamer "Three Rivers"

CITY OF BALTIMORE: (No. off Cove Point, Chesapeake ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Lester Seligman.

(a) RESIDENCE No. 1107 Sargeant Street. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 30, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Errand boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alfred Seligman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Amanda Dellinger.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant Amanda Seligman (mother).
(Address) 1107 Sargeant Street.

15 Filed JUL 8 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers" Accidental Death (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 7th, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 8 1924

20 UNDERTAKER H. W. Meaux Son, ADDRESS Balto Md

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

that it may be properly classified. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88440

D 88440

CERTIFICATE OF DEATH.

1789

1-PLACE OF DEATH On Steamer "Three Rivers"

CITY OF BALTIMORE: (No. off Cove Point, Chesapeake Bay ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas A.Pilker.Jr

(a) RESIDENCE NO. 8 Ridgecroft Road. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------.

6 DATE OF BIRTH (month, day, and year) July 6, 1911.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	11	29.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas A.Pilker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret E.Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Thomas A.Pilker.(father).
(Address) 8 Ridgecroft Road.

15 Filed JUL 8 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers"
Accidental Death (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)
July 7th, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL July 8 1924

20 UNDERTAKER H. H. Meaver Son ADDRESS Balto. Md

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-
to that it may be properly classified. PHYSICIANS should state

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88441

178 D 88441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: On Steamer "Three Rivers"

CITY OF BALTIMORE: (No.) off Cove Point, Chesapeake Bay (ST.) 24 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Walter C. Millikin.

(a) RESIDENCE NO 1148 Sargeant Street ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 8 mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------.

6 DATE OF BIRTH (month, day, and year) November 5, 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	8	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles C. Millikin.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary A. Schannon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14
Informant: Mary A. Millikin. (mother).
(Address): 1148 Sargeant Street.

15
Filed JUL 8 - 1924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers" Accidental Death

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

July 7th, 1924. (Address) 1217 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	July 8 1924
20 UNDERTAKER: H. W. Meador Son	ADDRESS: Balto Md

TION is very important. See instructions on back of certificate. Exact statement of occupation, so that it may be properly classified. PHYSICIANS should use plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88442

CERTIFICATE OF DEATH.

178D 88442

1-PLACE OF DEATH On Steamer "Three Rivers"

CITY OF BALTIMORE: (No. off Cove Point. Chesapeake Bay. ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson A. Miles.

(a) RESIDENCE No. 1185 Cleveland Street. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) November 29, 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Errand boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William E. Miles. Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine D. Plitt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Catherine D. Miles. (mother).
(Address) 1185 Cleveland Street.

15 Filed JUL 8 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers"

Accidental Death (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 7th, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Park Cem.	July 8 1924
20 UNDERTAKER H. W. Meaut Son	ADDRESS Balto Md

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88443

D 88443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 100 Beechdale Road-Roland Park-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Jennie Ellis Bowes

(a) Residence No. 100 Beechdale Road-Roland Park- 27 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 75 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bowes

6-DATE OF BIRTH (month, day and year) Feb. 14-1849

7-AGE.	If LESS than 1 day,
75 yrs. 4 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer..... None

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, ??? Warnock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant).. Miss Jane Bowes (daughter) (Address) 100 Beechdale Road-Roland Pk.

15- JUL 8 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7 1924

17- I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to July 7, 1924, that I last saw h.. alive on July 5, 1924, and that death occurred, on the date stated above, at 2-30 p. m.

The CAUSE OF DEATH* was as follows:

1. Chronic Nephritis

Coma. Intermittent

(Duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 1 yrs. 1 mos. 12 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) M. Gibson Porter, M. D.

7/7, 1924 (Address) 422 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New York City.	July 8..., 1924
20-UNDERTAKER STEWART & BOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Filled in EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88444

CERTIFICATE OF DEATH.

188-002 D 88444

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Kolpish

(a) RESIDENCE No. 636 Portland St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Paul Kolish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Kilanis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Paul Kolish
(Address) 636 Portland St.

15 Filed ..... 192 .....
JUL 8 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrage & Shock
(duration) a few minutes

CONTRIBUTORY (Secondary) Due over by M B via trauma
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Gourley, M. D.
(Coroner.)
7-7, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetary — DATE OF BURIAL July 8

20 UNDERTAKER Elias B. Kuchauskas — ADDRESS 637 S Bond

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

See Letter on file of July 10-1924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88445

D 88445

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. ..... ST., No WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brough

(a) RESIDENCE NO. 3207 E Fairmount Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Cora Brough

6 DATE OF BIRTH (month, day, and year) Oct 7-1869 Feb 18-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler-Engraver

(b) General nature of industry, business, or establishment in which employed (or employer) 038

(c) Name of employer

9 BIRTHPLACE (city or town) New York

(State or country) .....

PARENTS

10 NAME OF FATHER ~~Thomas~~ Jno. Brough

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) England Germany

12 MAIDEN NAME OF MOTHER Elizabeth Forrester Gerstman

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Canada Germany

14 Informant Cora Brough

(Address) 3207 E Fairmount Ave

15 JUL 8 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to July 5, 1924, that I last saw him alive on July 5, 1924, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Pleural effusion

(duration) ~~yrs.~~ mos 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? 3207 E Fairmount Ave?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Meths Autopsy

(Signed) Cayetano Paunetto, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 8th 24
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore.

~~mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.~~

~~—THIS IS A PERMANENT RECORD. Every infor-~~

Spec.—1-10-21—M&T—1500 Bks.

D88446.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D88446.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital. REGISTERED NO. 11

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Groff

(a) RESIDENCE No. Delta, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Groff

6 DATE OF BIRTH (month, day, and year) Feb. 22nd 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Delta, Pa.

PARENTS

10 NAME OF FATHER Benjamin Groff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Ida Tweedle, Delta, Pa. (daughter)
(Address)

15 FILED JUL 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 27th, 1924, to July 7th, 1924, that I last saw h living alive on July 7th, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix & abscess formation.

about
(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Hypertrophied prostate & cystitis; Broncho-pneumonia terminal.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? Yes Date of May 27th

Was there an autopsy? no.

What test confirmed diagnosis? Operation & clinical

(Signed) Saml Feiney, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oxford Pa. DATE OF BURIAL July 9 1924

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North Pa

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88447 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1017 Greenmount Ave. ST., 10 WARD)

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Seitz

(a) RESIDENCE No. 1017 Greenmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~the late~~ (or) ~~WIFE~~ of Rebecca Seitz.

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George L. Seitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs. Heidler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant M. George H. Seitz. (Address) 1908 Sherwood Ave

15 JUL 8 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to July 7, 1924, that I last saw him alive on July 6, 1924, and that death occurred, on the date stated above, at 5-40 A. m.

The CAUSE OF DEATH* was as follows: July 7th

Sarcomatosis - general

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Sarcoma Lymphosarcoma

(duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1921

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) Grant E. Ward, M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemy	July 10 1924
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E Eager St

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Barbara Heming)

D 88448 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88448

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bd. Sea Hosp'x. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Barbara Heming.

(a) RESIDENCE NO. 1634 Dudley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Heming

6 DATE OF BIRTH (month, day, and year) Feb'y 6 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Rudolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Veronica Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Henry Heming

(Address) 1634 Dudley Ave

15 Filed JUL 8 - 1924 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 8. 24 19

17 I HEREBY CERTIFY, That I attended deceased from 7-7-24, 19 ... to 7. 8. 24, 19 ..., that I last saw her alive on 7. 8. 24, 19 ..., and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Ch. Diff Emphysema

Ch. Myocarditis

A. Endocarditis

(duration) 5 yrs. mos ? ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

Arteriosclerosis (duration) 15 yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. Tests

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Bd Sea Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemy	July 10 19 24
20 UNDERTAKER	ADDRESS
Henry Hoach & Son	1301 E Eager

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

D 88449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88449

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Hoffman ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank. B. Stamhoff Jr.

(a) RESIDENCE No. 1827 Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 4 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Frank B Stamhoff Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret J. Snee

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mr Frank B. Stamhoff Sr.
(Address) 1827 Hoffman St

15 Filed JUL 8 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to July 6, 1924, that I last saw h[illegible] alive on July 6 - , 1924, and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Test at State Sanatorium

(Signed) Benj. S. Hayden, M.D.

7/7 1924 (Address) 216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL July 9 1924

20 UNDERTAKER Henry Hoen & Son — ADDRESS 1501 E Eager St

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement as to OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88450 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 90

City of BALTIMORE: (No. 3006 E Pratt St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine M. Bittel

(a) Residence No. 3006 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Bittel

6-DATE OF BIRTH (month, day and year): 2/29/1840

7-AGE: 84 yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At house

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Sebastan Schleicher

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Mrs. Anna Gerst Myer

(Address) 3006 E Pratt

15-JUL 8 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 7, 1924

17-I HEREBY CERTIFY, That I attended deceased from Jan 8th 1924 to July 7th 1924

that I last saw her alive on July 6 1924

and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C P Meier, M. D.

7/7/1924 (Address) 408 S Paca St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Ref. & Luth. Cem. DATE OF BURIAL: July 9, 1924

20-UNDERTAKER: John Merrick ADDRESS: 2008 Orleans

IMPORTANT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sherby

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88451

CERTIFICATE OF DEATH.

D 88451

31

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1273 Madison Ave ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest W. Sherby

(a) RESIDENCE No. 1273 Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clara E. Sherby

6 DATE OF BIRTH (month, day, and year) Feb 6 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Engineering

(c) Name of employer at Large

9 BIRTHPLACE (city or town) Boston (State or country) Mass

PARENTS

10 NAME OF FATHER Alex Sherby

11 BIRTHPLACE OF FATHER (city or town) Boston (State or country) Mass.

12 MAIDEN NAME OF MOTHER Alice Demaire

13 BIRTHPLACE OF MOTHER (city or town) Boston (State or country) Mass.

14 Informant Clara E. Sherby (Address) 1273 Madison Ave

JUL 8 - 1924 (Date Received) H. A. Mett (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to July 8, 1924,

that I last saw h— alive on July 7, 1924

and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

General tuberculosis. or Pulmonary T.B. secondary tuberculosis peritonitis.

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Fecal Cutaneous & Lymph conditions

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

7/ (Signed) Bernard S. French, M. D.

18, 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 9 1924
20 UNDERTAKER George J. Smith	ADDRESS 153 L Hollins

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 88452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88452

CERTIFICATE OF DEATH.

402

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 W. Gorsr ST., 27 WARD)

2-FULL NAME Frank Moore

(a) RESIDENCE NO. 142 W. Gorsr ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Moore

6 DATE OF BIRTH (month, day, and year) Nov 5 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	8	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dolgano'x.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Joe Moore -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Henrietta Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Moore

(Address) 142 W. Gorsr St

15 Filed JUL 8 - 1924 H. A. Mc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan - , 1924, to July, 5, 1924.

that I last saw h[illegible] alive on July, 4, 1924,

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

General Sepsis, Pyonephrosis Cystitis -

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Stricture of Urethra

(duration) yrs [illegible]

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Refused Hospital care.

What test confirmed diagnosis? Urine - Colon Bac.

(Signed) Dan'l Frank Lin M. D.

7/7, 1924 (Address) 142 W. Fay St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL July 8th 1924

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 88453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88453

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 123

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Christina Schenting

(a) Residence No. Fountain N. Monroll St. Park Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Frank Schenting

6-DATE OF BIRTH (month, day and year) April 9-187[illegible]

7-AGE. 53 yrs. 2 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hungary

PARENTS.

10-NAME OF FATHER Nathan Apatt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hungary

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Hungary

14-(Informant) Frank Schenting

(Address) Fountain and Monroll Park

JUL 8 - 1924 19

Received

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6/24

17- I HEREBY CERTIFY, That I attended deceased from 5/25 19 24 to 7/6 19 24

that I last saw h[illegible] alive on 7/6 19 24

and that death occurred, on the date stated above, at 5:25 A m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis ? chr. arteriosclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/1/24

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & examination

(Signed) H. V. Harper M. D

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 9 19 24

20-UNDERTAKER, F. D. Hyppert — ADDRESS 2256 Fulton Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88454

REGISTERED NO. 1172

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 24 WARD)

2-FULL NAME Mrs. Elizabeth Vandeschuh.

(a) RESIDENCE NO. 1702 Bond Street. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? Since Birth ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John N. Handschuh

6 DATE OF BIRTH (month, day, and year) Oct 9, 1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mr. James Healey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Miss Halfpenny.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Husband (Address) 1702 Bond Stret.

15 Filed JUL 8 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 6 1924 to July 6 1924, that I last saw h-- alive on July 6 1924, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix and Peritonitis Diffuse.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis Diffuse. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of July 6/1924.

Was there an autopsy?

What test confirmed diagnosis? Operation.

(Signed) Jno. A. Sappington, M. D.

, 19 (Address) 1111 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A. Co. DATE OF BURIAL July 10 1924

20 UNDERTAKER Margaret S. Flynn ADDRESS 1422 Eight St.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 88455 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88455

CERTIFICATE OF DEATH.

153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Healey

(a) RESIDENCE No. 2206 N Mowroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Radio Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J.F.C. Buck 916

9 BIRTHPLACE (city or town) (State or country) Ba New Jersey

PARENTS

10 NAME OF FATHER John J Healey

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ellen Houlahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant (Address) Mrs Ellen Healey 2206 N Mowroe st

15 Filed JUL 9 1924 Registrar H. A. Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to July 9, 1924, that I last saw him alive on July 7th 1a.m., 1924, and that death occurred, on the date stated above, at 5.22 a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Face, Arbited Region and Neck

Two weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/4/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. E. Chambers M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/9 24
20 UNDERTAKER	ADDRESS
Edgett Turkey Sullivan	Fayette

MARK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

D 88456 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1422 Patapsco St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Viehmeyer

(2) Residence No. 1422 Patapsco St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Viehmeyer

6-DATE OF BIRTH (month, day and year) Jan. 18 1844

7-AGE.	If LESS than 1 day.
80 yrs. 5 mos. 18 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Peter Schramm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Ruck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mr. Wm. Viehmeyer

(Address) 1422 Patapsco St.

JUL 8 - 1924

(Received)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6 - 1924

17- I HEREBY CERTIFY, That I attended deceased from July 4" 19 24 to July 6" 19 24

that I last saw h[illegible] alive on July 5 19 24

and that death occurred, on the date stated above, at 11.45 Am.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Venous Ulcer

(Duration) 7 yrs. 10 mos.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M D

, 19 (Address) 1340 Cloverhill

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	July 9..., 1924
20-UNDERTAKER. D. Fenwick McCully	ADDRESS 130 E. Fort Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88457

CERTIFICATE OF DEATH.

161-001 D 88457

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 McElderry St.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfielder

(a) RESIDENCE. No. 3034 McElderry ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8. 24

7 AGE Years Months Days | If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Winfielder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Margaret Fleshman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Margaret Winfielder

(Address) 3034 McElderry St

15 Filed JUL 8 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

1587

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8. 24, to July 8 24, that I last saw h— alive on July 8 24, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Mysaul, M. D.

(Address) 811 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Rohrer State Board

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS [illegible] JUL 8 1924

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88458

CERTIFICATE OF DEATH.

161-001 D 88458

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 McElderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfelder

(a) RESIDENCE. NO. 3034 McElderry ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fmle

4 COLOR OR RACE Colrd

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8. 20

7 AGE Years — Months — Days — If LESS than 1 day, ... hrs. or 30 mn.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Winfelder

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Heisler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Margaret Winfelder
(Address) 3034 McElderry St

15 JUL 8 - 1924 ROBERT R. KRAUTER, Registrar
1588 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1924, to July 8, 1924, that I last saw h[illegible] alive on July 8, 1924, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Immature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

(Address) 1918 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Rohrer State Board — DATE OF BURIAL 19

20 UNDERTAKER [illegible] — ADDRESS [illegible] 8-10

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88459

CERTIFICATE OF DEATH.

3 D 88459

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 Thames ..... St., 3 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Kielsee

(a) Residence No. 1510 Thames ..... St., 3 ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 26th 1908

7-AGE. 16 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)..... attendant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Herman H. Kielsee

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Mary A. Rolfes.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant). Capt. Herman H. Kielsee

(Address) 1510 Thames St.

15- JUL 8 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..., to July 6 19 24 that I last saw h live on July 3 19 24 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Pthisis ? Pond

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? — —

Did an operation precede death? Date of

Was there an autopsy? Clinical Study

What test confirmed diagnosis? G. W. C. Brady

(Signed) ..... M. D.

. 19 (Address) 1426 N Bway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	July 9th, 1924
20-UNDERTAKER, Lilly Zieler	ADDRESS 1008 S. Moffett

In filling out this certificate, EVERY item of information requested should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88460

CERTIFICATE OF DEATH. 113

D 88460

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2004 Gough St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. August M Ruggles

(Residence in Baltimore: No. 2004 Gough St; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	Whe	Sngl

6-DATE OF BIRTH. April (Month) 27 (Day) 19 (Year)

7-AGE. ....yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 0 0

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Vernon T Ruggles

11-BIRTHPLACE OF FATHER, (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER. E Oibel

13-BIRTHPLACE OF MOTHER, (State or Couutry). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Vernon Ruggles

(Address)....2004 Gough

15- ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

JUL 8 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 7 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) 6 mos Gastritis

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D.
(Coroner.)

192 4 (Address) Fort Chas

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL, 7/9 1924

20-UNDERTAKER. A. Otto Heimann ADDRESS 2 N Broad.

Only items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 88461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88461

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1302 John St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen G. Patterson

(a) Residence No. 1302 John St., Ward.....

(Usual place of abode) 50 Lifetime (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John S. Patterson

6-DATE OF BIRTH (month, day and year) Dec 8-1867

7-AGE. 56 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Co. Md.

PARENTS.

10-NAME OF FATHER. Wm H. Hutchins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER Mary Clarke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) John S. Patterson

(Address) 1302 John St.

15- FILED JUL 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7-1924

17- I HEREBY CERTIFY, That I attended deceased from January 1, 1924, to July 7, 1924, that I last saw h.. alive on July 3, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(Duration) ..... yrs. ..... mos. 4 days

CONTRIBUTORY (Secondary) Cer. Sclerosis & Bright's dis.

(Duration) not known yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard D. Dorman M. D

July 7, 1924 (Address) 5 E. Lexington St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, 7/9 1924

UNDERTAKER, Chas. P. Crane & Son

ADDRESS 118 West Royal Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88462

CERTIFICATE OF DEATH.

D 88462

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac Fleishman

(a) Residence No. Mount Hope Retreat St., 28 Ward Richmond Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 10 1858

7-AGE,	If LESS than 1 day,
71 yrs. 0 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (Richmond (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, William Fleishman

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Hofmayer

13-BIRTHPLACE OF MOTHER (city or town) Demuth (State or Country), Germany

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Md

15- By JUL 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 5-24

17- I HEREBY CERTIFY, That I attended deceased from May 9 1924 to July 5, 1924, that I last saw h[illegible] alive on July 7 *, 1924, and that death occurred, on the date stated above, at 12:15 midnight m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 2 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Nephritis

(Duration) life time yrs. mos. ds.

18-Where was disease contracted if not at place of death? Richmond Va

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Richmond Va	July 8, 1924
20-UNDERTAKER.	ADDRESS
Wm J Tickner Sons	Roxbury Pa Ave

Be sure that EVERY ITEM is accurately and completely answered. Every item of information requested EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88463

CERTIFICATE OF DEATH.

90

D 88463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Garrison Blvd ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes M. Wallace

(a) RESIDENCE. NO. 3017 Garrison Blvd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 31-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phil. Pa

PARENTS

10 NAME OF FATHER: Robert Glassey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Jane Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Robert M. Wallace

(Address) 3017 Garrison Blvd

15 JUL 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15 1924, to July 8 1924, that I last saw h.. alive on July 8 1924, and that death occurred, on the date stated above, at 11 35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - C Valvular Lesions.

(duration) Several yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) Austin F. Robinson M. D.

7/8 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	July 9 24

20 UNDERTAKER: Chas. E. Bauck & Son

ADDRESS: Madison Av

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(See Letter over)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 88464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 88464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Rabora ST.: W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Carroll

(a) RESIDENCE. No. 703 Rabora ST., WARD. Galena Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. one mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fmal

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Widow.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Alfred Carroll

6 DATE OF BIRTH (month, day, and year) Jan 12-1863 or Mar. 11. 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59	50	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Henry Peaker

11 BIRTHPLACE OF FATHER (city or town) Kent Co Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Kent Co Md (State or country)

14 Informant Annie E Wilson (Address) 703 Rabora

15 Filed JUL 8 - 1924 ROBERT R. KRABTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to July 6, 1924, that I last saw h[e] alive on July 6, 1924, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

(Cerebral Hemorrhage Apoplexy.)

(duration) yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) H. E. Clark, M. D.

July 7 (Address) North Ave & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Galena Md Cemetery July 8 1924

20 UNDERTAKER ADDRESS

Geo Gotthardt Galena Md

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified: Exact statement of OCCUPATION is very important. See instructions on back of certificates. THIS IS A PERMANENT RECORD. Every item of information should be written PLAINLY WITH INDELIBLE INK.

REG. NO. 695

DATE .....

DR. F. C. LINK

NORTH AVE. AND DIVISION ST.

PHONE, MADISON 2169

OFFICE HOURS:
8 TO 7.30 P. M.

Oct 10 17

℞ PATIENT'S NAME ..... ADDRESS .....

The family of Emma Carroll say she was born Jan 12-1865 Kindly give them correct transcript. They will pay for same.

D 88464
age 59-5-25

F. C. Link.

FULL NAME ..... M. D.

A. LAPOURAILLE
DRUGGIST
S. W. Cor. Caroline & Orleans Sts.
PHONE CONNECTIONS BALTIMORE

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88465

CERTIFICATE OF DEATH.

47 D 88465

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 N. Fremont Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Amelia Shipley Javins

(a) Residence No.....709 N. Fremont Avenue St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Granderson D. Javins

6-DATE OF BIRTH (month, day and year) Apr. 26, 1846

7-AGE, 78 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Daniel Lepson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Arabella Etherington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant).....Miss Alice M. McFrederick

(Address).....623 N. Carrollton Ave.

JUL 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to July 8, 1924, that I last saw her alive on July 7, 1924, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

carcinoma of breast becoming a generalized carcinomatosis ending with cardiac insufficiency

.....(Duration)...4...yrs...2...mos...23...ds.

CONTRIBUTORY (Secondary) cardiac insufficiency

.....(Duration)...2...yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....7.54 Columbia Ave.....

Did an operation precede death? Yes Date of May 18, 1920

Was there an autopsy? no Nov. 17, 1923

What test confirmed diagnosis? Microscopical diagnosis

(Signed) George Klump, M. D.

7-8-1924 (Address) 1002 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	July 10, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 W. Lanvale

IMPORTANT—Should be Carefully Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88466

CERTIFICATE OF DEATH.

D 88466

Registered No. 74-001 88466

1-PLACE OF DEATH

City of BALTIMORE: (No. 541 W. Conway St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lucy M. Hoffman

(a) Residence No. 541 W. Conway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, ~~HUSBAND of~~ (or) WIFE of Charles Hoffman

6-DATE OF BIRTH (month, day and year) April 19 1868

7-AGE, 55 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Frederick Schesterlent

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germy

12-MAIDEN NAME OF MOTHER, Caroline Dorn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Philadelphia Pa

14-(Informant) Charles P. Hoffman

(Address) 541 W. Conway St

JUL 8 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7 1924

17- I HEREBY CERTIFY, That I attended deceased from May 3 1923 to July 7 1924

that I last saw her alive on July 7 1924

that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Clarence P. Eberbach M. D.

July 8 1924 (Address) 1412 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	July 10 1924
20-UNDERTAKER.	ADDRESS
Jos Jourdens Son	2178 Pac

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88467

D 88467

CERTIFICATE OF DEATH.

36-005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Stockton ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Curtis

(a) RESIDENCE. NO. 1325 Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Curtis.

6 DATE OF BIRTH (month, day, and year) Oct 12. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...Ob

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) St Marys Co., Maryland.

PARENTS

10 NAME OF FATHER James Dallas Curtis

11 BIRTHPLACE OF FATHER (city or town) St Marys Co (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Amelia Jones

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or country) Md.

14 Informant: Mary Eva Curtis. (Address) 1325 Stockton St.

15 Filed JULY 8 1924 ROBERT R. KNAUER, Burial Permit Clerk. Registrar

Hollywood.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 24.

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to July 6, 1924, that I last saw h.. alive on July 5, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Enlarged Thyroid

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? St Mary's Co Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

1924 (Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mrs Geo. H. Dennis St Mary's Co Md	July 9 1924
20 UNDERTAKER	ADDRESS
Mrs Jno. H. Dennis per T. E. Kelson	1303 Preston St

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88468

CERTIFICATE OF DEATH.

74-201

D. 88468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Frost St., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Parker

(a) RESIDENCE NO. 2716 Frost St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND (or) WIFE Wm H Parker

6 DATE OF BIRTH (month, day, and year) Feb 20 1883 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs. H. Parker
(Address) 2716 Frost St

15 Filed JUL 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above. (Autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

(Signed) Jno. J. Morrissey, M. D.
(Coroner.)

July 8, 1924 (Address) 1632 Richardson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 9 1924
20 UNDERTAKER	ADDRESS
CHENOWETH & SON	917 CHESTNUT AVE

Cor.—1-12-23—M&T—100 Bks.

D 88469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88469

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1524 Riggs ST., 16 WARD)

2-FULL NAME Chas. Booker

(a) RESIDENCE NO. 1524 Riggs Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colrd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Booker.

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sign Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Rosie Booker
(Address) 1524 Riggs Av.

15 Filed JUL 9 - 1924 192 GG. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

July 8, 1924 (Address) 2802 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion cemetery	July 8th 1924
20 UNDERTAKER Joseph A Farrell	ADDRESS 1319 Division St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88470 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 88470**

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 98 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Cucula

(a) RESIDENCE NO. 919 W. Lombard St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) April 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Paulo Cucula

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Paulena Stankus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14
Informant Father
(Address)

15
Filed JUL 9 - 1924
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17
I HEREBY CERTIFY, That I attended deceased from July 9 1924, to July 9 1924,
that I last saw him alive on ....., died on way to Hospital
and that death occurred, on the date stated above, at 1:00 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) Bllraagnaan, M. D.
7/9/24 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 9 1924
20 UNDERTAKER	ADDRESS
John Grebliauckas	426 S. Bond St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88471 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2576 Madison Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Susanna Galeb

(a) Residence No. 2576 Madison Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1845

7-AGE, 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER Wm Williams

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Prudence Hess

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Md

14- (Informant) Mrs Joseph Richardson

(Address) Catonsville Md

15- JUL 9 - 1924 ....., 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1924 to July 7 1924

that I last saw h.. alive on July 7 1924

and that death occurred, on the date stated above, at 5.05 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Gardiner M. D

, 19 (Address) Towson Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 9, 1924

20-UNDERTAKER: Wm Cole & Son — ADDRESS: Baltimore

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88472

CERTIFICATE OF DEATH

D 88472

1-PLACE OF DEATH Union memorial Hospital X

REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James P. Culp.

(a) RESIDENCE NO. Rock Hill. S ST., ... WARD South Carolina
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ds. 23 How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (WIFE) of Mrs. James P. Culp

6 DATE OF BIRTH (month, day, and year) July 4. 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance agent.

(b) General nature of industry, business, or establishment in which employed (or employer) 071

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER W. S. Culp

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary Mc. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Jennie Culp
(Address) Rock Hill S Carolina

15 Filed JUL 9 - 1924 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to July 8, 1924, that I last saw him alive on July 8, 1924, and that death occurred, on the date stated above, at 5.05 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Post operative Hemorrhage

(duration) 2 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6-23-24 7-8-24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Price S.C.	8/8 1924
20 UNDERTAKER Herman Cook	ADDRESS 502 E Nash

REGISTRAR—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Becker

(a) Residence No. 2206 Callow St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ada Becker

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Europe

PARENTS.

10-NAME OF FATHER, Hedwa Becker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Hospital Records

(Address)

15-

JUL 9 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 8 24

17- I HEREBY CERTIFY, That I attended deceased from 7/2/24, 19 to 7/8/24 19

that I last saw h. alive on 7/8/24 19

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/3/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. W. Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Rod Rd	July 9, 1924
20-UNDERTAKER,	**ADDRESS**
Jack Lewis	1439 E Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88474

CERTIFICATE OF DEATH.

D 88474

1887

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Univ Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Matthews

(a) RESIDENCE NO. 1829 N Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cable Splicer
(b) General nature of industry, business, or establishment in which employed (or employer) C & P Tel Co
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Jno P Matthews

11 BIRTHPLACE OF FATHER (city or town) Penn.
(State or country)

12 MAIDEN NAME OF MOTHER Mary A Philcox

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary A Matthews
(Address) 1829 N Monument

15 Filed JUL 9 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Dea death on the day stated above.

The CAUSE OF DEATH was as follows:* Accident
Motor Cycle
Multiple Fracture
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. 1 ds.

(Signed) Gid Ellwood Rader, M. D.
(Coroner.)
July 7 1924 (Address) 1715 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery Co

20 UNDERTAKER J. G. Moran

DATE OF BURIAL 7/10 1924

ADDRESS 3 Eo E Baltimore

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S RECORD. Every line of information must be supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 88475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88475

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

City of BALTIMORE, (No. St. Agnes Hospital St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mannie Mc Donnell

(a) Residence No. 2730 St. Paul St City St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 45 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE, 60 yrs. -- mos. -- ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), [illegible], Ireland

PARENTS.

10-NAME OF FATHER, John McDonnell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Hannorah -----

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mannie Mc Donnell

(Address) 2730 St Paul St

15- JUL 9 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from 6-17 19 24 to 7-8 19 24

that I last saw h[illegible] alive on 7-8 19 24

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Pancreas (4 mos)

Diabetes Mellitus 12 yrs.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Sdgs + Lab.

(Signed) H V Harper M. D

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, 7/11 19 24

20-UNDERTAKER, Henry W. Mears & Son — ADDRESS 805 N. Calvert

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 4a.

D 88476 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88476

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Chidley

(a) RESIDENCE No. 1317 Lemon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	54	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D. C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Annie Chidley
(Address) 1317 Lemon St

15 FILED JUL 9 - 1924 H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 19 24 to July 7, 19 24.

that I last saw h m alive on July 7, 19 24

and that death occurred, on the date stated above at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Traumatic stricture of urethra + Chr. nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical data

(Signed) L. K. Fargo, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7/9/24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1503 Blks.

1728 D 38477 HEALTH DEPARTMENT—CITY OF BALTIMORE D 38477

65-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earnest Lucky

(a) RESIDENCE NO. 116 N. Biddle ST., St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Stated

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) +

(c) Name of employer +

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Earnest Lucky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) Johns Hopkins Hosp.

Filed JUL 9 - 1924 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6 - 1924 to July 7 - 1924, that I last saw him alive on July 2 - 1924, and that death occurred, on the date stated above, at 1.00 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Lymphatic Leucaemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) C. B. MacCarty M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7/9/24

20 UNDERTAKER Daniel Eastord

ADDRESS 916 Park ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88478

CERTIFICATE OF DEATH.

160 D 88478

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 N Amity ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Montal J White

(Residence in Baltimore: No. 226 N amity St.; ....yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, Col.

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Apr 22, 1924
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bal Co

PARENTS.

10-NAME OF FATHER, Cornelius Richardson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Bessie White.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie White

(Address) 226 N Amity St.

15- JULY 9 - 1924 191.. H. Devine
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1924, to July 8 1924, that I saw h..im alive on July 8 1924, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) A. N. King M. D.

....., 191... (Address) 625 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	7/9/24
20-UNDERTAKER	ADDRESS
Daniel Earhart	916 Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 11ks.

D 88479 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 88479**

CERTIFICATE OF DEATH. 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 530 1/2 Greenmillst. (ST.) 17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Ford

(a) RESIDENCE NO. 636 Greenmillst. ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph. Ford,

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Amos Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Cecil Ford
(Address) 636 Greenmillst.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

2 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Indiscretion of diet,

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

July 7, 1924 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	7/9/24
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 88480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88480

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH Off Cove Point, Chesapeake Bay.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Brogden. (C)

(a) RESIDENCE No. 706 Brune St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. -- mos. 3 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced, HUSBAND of [illegible] Alice Brogden. (C)

6 DATE OF BIRTH (month, day, and year) July 2, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pantry man, 070
(b) General nature of industry, business, or establishment in which employed (or employer) Steamer "Three Rivers"
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Brogden. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Henrietta Jones. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Orleans. La.

14 Informant Alice Brogden. (C) wife.
(Address) 706 Brune St.

15 Filed [illegible] 192 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

Investigation

The CAUSE OF DEATH* was as follows:

Drowning, Jumped into the water from the burning steamer "Three Rivers" Accidental Death

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)
..... 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	7/9/24
20 UNDERTAKER Daniel Easton	ADDRESS 916 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8848[illegible]

D 8848[illegible]

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 E 23 ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver James Frisby

(a) RESIDENCE NO. 308 E. 23 St ST., 12 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of / WIFE of Mrs Lizzie Frisby

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Washing and repairing cars

(c) Name of employer Frank Roe. 23

9 BIRTHPLACE (city or town) (State or country) Harford Co Maryland

PARENTS

10 NAME OF FATHER James Frisby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Md

12 MAIDEN NAME OF MOTHER Mrs Ida Gorden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md.

14 Informant Sophie Wife (Address) 308 E 23rd St.

JUL 9 - 1924 ile T. Ham Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to July 7, 1924, that I last saw him alive on July 7, 1924, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Oedema of glottis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank Saunders M. D.

, 19 (Address) 1123 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 11 1924
20 UNDERTAKER	ADDRESS
Mrs. P. G. Elliott	1225 Eastlander.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

—THIS IS A PERMANENT RECORD. Every item of infor-

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2929 W North ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lord Bishop

(a) Residence No. 2929 W North ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lamartyne Bishop

6-DATE OF BIRTH (month, day and year) July 8, 1860

7-AGE. 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Geo Ward

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto md

12-MAIDEN NAME OF MOTHER, Susan Richards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto md

14- (Informant) Miss Elizabeth Ward

(Address) 2929 W. North ave

15- JUL 9 - 1924 (Date received) H A Mc (Registrar)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6. 24

17- I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to July 5, 1924, that I last saw h.. alive on July 5 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) — yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Lewis M Gay, M. D.

, 19 (Address) 1014 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL, July 9, 1924

20-UNDERTAKER. John C. Mitchell

ADDRESS 201 W Fayette St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88483

CERTIFICATE OF DEATH.

D 88483

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vinson Thomas

(a) RESIDENCE No. 130 N.Bond St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 3 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Apr 2/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marian Canty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm. Thomas
(Address) 130 N. Bond St

Filed JUL 9 - 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis

(Diagnosis at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Cain, M. D.
(Coroner.)

7/9/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury Cemetery	July 10 1924
20 UNDERTAKER Edward Bryson	ADDRESS 1631 Orleans

Spec.—1-10-21—M&T—1500 Blks.

D88484 (Endle) HEALTH DEPARTMENT—CITY OF BALTIMORE 124 D-88484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N Loudoun St., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Endle

(a) RESIDENCE NO. 1209 N Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Endle

6 DATE OF BIRTH (month, day, and year) Dec 25 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Ironer

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Endle

(Address) 1209 N Lombard

15 JUL 9 - 1924 Filed H. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to July 8, 1924, that I last saw him alive on July 8, 1924, and that death occurred, on the date stated above, at 1230 A. M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo Kreegmann M. D.

July 9th (Address) 1900 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 10 1924

20 UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—[illegible]—400 Bks.

D 88485

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 871 N. Curley St. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Martin D. Meyer

(a) Residence No. 871 N. Curley St. St., 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosaltha Meyer.

6-DATE OF BIRTH (month, day and year) Nov. 13-1849

7-AGE, 74 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Meyer.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-(Informant) George Meyer (Son)

(Address) 311 S. 13th St.

15- JUL 9 - 1924 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 to 19 to July 7th 19 24

that I last saw him alive on July 5th 19 24

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows: Pneumonia Contracted

Left Fib. Knee & foot

Ulcer (Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Rickard M. D

7-7- 1924 (Address) 608 Hollins

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Chase Balto Co Home burying Ground. md

DATE OF BURIAL. July 10th 1924

20-UNDERTAKER, Lilly and Zeller

ADDRESS 403 S. Wolfe St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88486 (Thim) HEALTH DEPARTMENT—CITY OF BALTIMORE D 88486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 333 S Robinson St. 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry H Thim

(Residence in Baltimore: No. 333 S Robinson St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	white	S

6-DATE OF BIRTH, Sept (Month) 16 (Day) 1920 (Year)

7-AGE, 3 yrs. 9 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Anthony Thim

11-BIRTHPLACE OF FATHER, (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Mary Mauler

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE ~~TO THE~~ BEST OF MY KNOWLEDGE.

(Informant) Anthony Thim

(Address) 333 S Robinson St

15- JUL 9 - 1924 H. A. M. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 7 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3° Burns of Chest & Face
by Explosion July 4 1924
Accident

(Duration) 0 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Inhalation Pneumonia

(Duration) 0 yrs. 2 mos. 1 ds.

(Signed) Thos M. Fenton M. D. (Coroner.)

July 7 1924 (Address) 700 Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cem.	July 9 1924
20-UNDERTAKER, Lilly & Zeller	ADDRESS 1103 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 4-9-19—H. R. Co. 2000 Bks.

D 88487 D 88487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Ansquith ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wilson

(a) RESIDENCE. No. 713 Ansquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Fred. Chas. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Violet G. Crapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fred. Chas. Wilson
(Address) 713 Ansquith st

15 Filed JUL 9 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 24

17 I HEREBY CERTIFY, That I attended deceased from 7-8, 19 24, to 7-8, 19 24, that I last saw h. alive on 7-8-24, 19, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Anencephalus

(duration) yrs. mos. 3 hrs ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Delivery of Child

(Signed) David Miller M. D.

, 19 (Address) 1500 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 9 1924
20 UNDERTAKER	ADDRESS
Henry Horch & Son	1301 E Eager St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88488 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 88488**

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE, (No. 841 S. Ellwood ave St., 1 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. O'Connor

(a) Residence No. 841 S. Ellwood ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 12-1906

7-AGE. 17 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER Thos. F. O'Connor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER Anna V. Hopkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Anna V. O'Connor

(Address) 841 S. Ellwood ave

15- Filed JUL 9 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6-1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to July 6, 1924 that I last saw h[illegible] alive on July 6, 1924 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(Duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Cat.

M. D. (Address) 839 S. Ellwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, 7/10 1924

20-UNDERTAKER J. F. Moran — ADDRESS 3008 E. Baltimore

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88489

CERTIFICATE OF DEATH.

100-001 D 88489

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Shields Place ST., 17 WARD)

2-FULL NAME Evelyne Ward.

(a) RESIDENCE NO. 904 Shields Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 11 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Butte (State or country) Mont.

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie Gibson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Judge Ward (Address) 904 Shields Place

15 Filed JUL 9 - 1924, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17

I HEREBY CERTIFY, That I attended deceased from July 8th 1924, to July 8 1924, that I last saw h[illegible] alive on July 8. 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Bernard L. Swan, M. D.

7/8 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-10 1924
20 UNDERTAKER George I. A. Gibson	ADDRESS 1706 Druid Hill Ave

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 88490

CERTIFICATE OF DEATH.

D 88490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH On Steamer "Three Rivers"

CITY OF BALTIMORE: (No. Off Cove Point, Chesapeake Bay ST., 17 WARD)

2-FULL NAME Robert Watkins. (C)

(a) RESIDENCE NO. 755 Bradley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 12 ds. How long in U. S., If of foreign birth? ---- yrs. ---- mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 23, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck hand,

(b) General nature of industry, business, or establishment in which employed (or employer) Steamer

(c) Name of employer "Three Rivers"

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Robert E. Watkins. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah Jones. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co. Md.

14 Informant Sarah Watkins. (C) mother.

(Address) Lincoln Park Prince Georges

15 Filed ....., 192.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by smoke and body cremated by fire aboard the steamer "Three Rivers" Accidental Death (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

7-9, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremated	July 10 1924

20 UNDERTAKER Wm. H. Grace & Son ADDRESS 1400 Mosher

FROM IF very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88491

CERTIFICATE OF DEATH.

D 88491

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Penna Ave 17 ST.: WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estie Green

(a) RESIDENCE: No. 1108 Penna Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Baggett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Connie Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joshua Baggett

(Address) 1108 Penna Ave

15 Filed JUL 9 - 1924 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-21, 1924, to 7/7, 1924

that I last saw her alive on 7/5, 1924,

and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Hunts T Stephnts

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) William A Harris, M. D.

7-9 1924 (Address) 1100 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brews Chapel A.M.E. Ch

DATE OF BURIAL July 10 1924

20 UNDERTAKER Sam'l N. Chase & Son

ADDRESS 1400 Mosher

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88492

CERTIFICATE OF DEATH.

D 88492

100-001

REGISTERED NO.

1-PLACE OF DEATH Ass Sisters Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Dayson ST., 19 WARD)

2-FULL NAME Miss Mary Kelly

(a) RESIDENCE NO. 19 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 22nd 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Coyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Michael Gorman

(Address) 19 N Fulton Ave

15 Filed 7/8/24 H. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to July 8, 1924, that I last saw her alive on July 8, 1924, and that death occurred, on the date stated above, at 10 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 21 24

Was there an autopsy? No. Removal Gall Duct

What test confirmed diagnosis? Operation; clin. & Lab. Sig

(Signed) H. W. Dorsey M. D.

7/8/ 1924 (Address) Ass Sisters Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 11 1924
20 UNDERTAKER Gotwals Keppler & Son	ADDRESS
per P. J. Cowan	701 Fallsway

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88493

D 88493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospital 26 78 Registered No.....

City of BALTIMORE: (No. Bay View ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Patrick

(a) Residence No. Bay View Asylum ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black.

5-~~Single~~, ~~Married~~ Widowed, ~~or Divorced~~, (Write the word.) Widowed.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1886.

7-AGE. 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown.

14- (Informant) Hospital Records.

(Address).....

JUL 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July-6-24

17- I HEREBY CERTIFY, That I attended deceased from May 26. 1924. to July 6. 1924.

that I last saw h im alive on July 6. 1924.

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Left Sided Hemaplegia + Epilepsy

(Duration) 1. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical + Laboratory Test

(Signed) Jas. P. Kemp M.D. M. D.

19 (Address) Municipal Hospital, Balto Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. ..... 19...

20-UNDERTAKER. ADDRESS.

UNIVERSITY OF MARYLAND

JUL 9 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

219

1590

Spec.—1-10-21—M&T.—1500 Bks.

88494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 88494

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 741 E Preston St., 10 WARD)

2-FULL NAME Infant Bromwell

(a) RESIDENCE NO. " " ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/9 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9 hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER J. Orville Bromwell

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Theresa Dickel

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Dr (Address) 741 Preston

15 JUL 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9 1924

17 I HEREBY CERTIFY, That I attended deceased from July 19.. to July 9 19 24. that I last saw him dead " ., 19 .., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: (a) Premature Birth Syn.

(b) Cause unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) not a caught child (duration) 9 hrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Henry H Cassidy, M. D.

(Address) 1 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 7/10 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 N Mt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88495

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William May

(a) RESIDENCE. No. 727 S. Broadway St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John May

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Municipal Hospital Records

(Address)

15 JUL 9 - 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-4, 1924 to 7-9, 1924

that I last saw him alive on 7-8, 1924

and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

Myocardial Insufficiency (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude B. Drane, M. D.

7-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	July 10. 1924
20 UNDERTAKER	ADDRESS
M F. Sadowski	705 S. Ann

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88496

D 88496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 297 Pulaski ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Stengler

(a) RESIDENCE (Usual place of abode) No. 297 Pulaski ST., WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Stengler

6 DATE OF BIRTH (month, day, and year) Oct 23 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida Stengler

(Address) 297 Pulaski St

15 JUL 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 8, 1924.

that I last saw h.. alive on July 7, 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia, Nephritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At Business

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F. Gray M. D.

19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL July 11. 1924

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk. Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1731 D 88492

CERTIFICATE OF DEATH.

D 88497

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth White

(a) RESIDENCE NO. Great Falls, S.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. —mos. 2ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Killough White

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Liggie Hankerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 JUL 9 - 1924. ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1924, to July 8, 1924.

That I last saw her alive on July 8, 1924

and that death occurred, on the date stated above, at 310 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebella, cystic glioma (locally malignant)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 8

Was there an autopsy? yes

What test confirmed diagnosis? Palpation

(Signed) F. C. Reichert M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester So. Carolina — DATE OF BURIAL: 7/9/24

20 UNDERTAKER: H. E. Hughes ADDRESS: 424 N Broadway

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88498

CERTIFICATE OF DEATH.

16 D 88498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital 15 WARD)

2-FULL NAME Robert Lee Sykes

(a) RESIDENCE NO. 35 11 Wilbrod Ave, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. General Hospital

PARENTS

10 NAME OF FATHER Thomas B. Sykes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Yorkshire Eng.

12 MAIDEN NAME OF MOTHER Helen Dorney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford Co. Md.

14 Informant mother

(Address) 35 11 Wilbrod Ave.

15 Filed JUL 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to July 9, 1924, that I last saw him alive on July 9, 1924, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the Newborn.

(duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Jno A Donnelly, M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem.	July 10 1924
20 UNDERTAKER	ADDRESS
Wm R. Blackford	N Broadway

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88499

CERTIFICATE OF DEATH.

D 88499

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3903 Hawthorne Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Herbert Burns

(a) RESIDENCE No. 3903 Hawthorne Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9.1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	50	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Masonic Instructor

(b) General nature of industry, business, or establishment in which employed (or employer) Masonic Fraturnity

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles W.H.Burns

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Adeline Benton

13 BIRTHPLACE OF MOTHER (city or town) Alexander

(State or country) Wash.D.C.

14 Informant Adeline B.Burns

(Address) 3903 Hawthorne Ave

15 JUL 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9.1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to July 8, 1924, that I last saw him alive on July 8, 1924, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	7-11-24 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88500

CERTIFICATE OF DEATH.

100-001

D 88500

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3804 Forest Park Ave ST. 15 WARD)

2-FULL NAME Isabella Winchester Woolford

(a) RESIDENCE NO. 3804 Forest Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yr LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a [illegible] widowed, or [illegible] HUSBAND of (or) WIFE of James W Woolford

6 DATE OF BIRTH (month, day, and year) Sept 10th. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rose Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Arthur Woolford

(Address) 220 39th. St.

15 JUL 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/24 19

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to July 7, 1924, that I last saw h[illegible] alive on July 7, 1924, and that death occurred, on the date stated above, at 12:55 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocarditis

[illegible] (duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. [illegible] M. D.

July 7, 1924 (Address) 4309 Fairfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 7/10/24 19

20 UNDERTAKER: H. E. Hughes 424 N. Broadway — ADDRESS

P. S.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88501

CERTIFICATE OF DEATH.

179 D 88501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N. Fayette ST., 19 WARD)

2-FULL NAME Rose Celeste Linthicum

(a) RESIDENCE No 1327 N. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John N. Linthicum

6 DATE OF BIRTH (month, day, and year) May 8th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John N. Harris

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Rhoderick

13 BIRTHPLACE OF MOTHER (city or town) N. Y.
(State or country)

14 Informant John N. Linthicum
(Address) 1327 N. Fayette St.

15 JUL 9 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo. D. Arthur, M. D.
(Coroner.)

July 8 1924 (Address) Curtis Bay, Md

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: July 10, 1924

20 UNDERTAKER: Rose B Cook — ADDRESS: 1003 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—10-21—M&T—1500 Bks.

13160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88502

CERTIFICATE OF DEATH.

D 88502

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Burton

(a) RESIDENCE No. 98 Winters Ave. ST., WARD Catonsville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Augustus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lizzie Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 9 - 1924 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1924, to July 9, 1924.

that I last saw him alive on July 9, 1924

and that death occurred, on the date stated above at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Renal Function Test

(Signed) A. W. Jacobson M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cem	July 12 1924
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

R. 6. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88503

CERTIFICATE OF DEATH.

D 88503

REGISTERED NO. 1632

1-PLACE OF DEATH Woman's Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby Mitchell

(a) RESIDENCE NO. 1630 E Eager ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	still born

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm E. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Beatrice Evans.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mother (Beatrice Mitchell)
(Address) 1630 E. Eager

15 JUL 9 — 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to July 7, 1924
that I last saw he alive on July 7, 1924
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Asphyxia
Prolapse of Cord

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) John M Bergland, M. D.
, 19 (Address) 58 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	July 10 1924
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 W. Broadway

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88504

CERTIFICATE OF DEATH.

D 88504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Dolphin ST.; ... WARD)

2-FULL NAME Mary Lilly Keene

(a) RESIDENCE. NO. 529 Dolphin ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Keene

6 DATE OF BIRTH (month, day, and year) Jan 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employment Agency

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER James Ryon Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Md

12 MAIDEN NAME OF MOTHER Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Ruth M. Webb
(Address) 529 Dolphin

15 Filed JUL 10 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to July 8, 1924 that I last saw h. alive on July 7, 1924 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Vagina 5

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia Volvulus. Uremia Exhaustion 1 5

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm H Wright M. D.

July 9, 19 24 (Address) 1209 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels. Md	July 11 1924

20 UNDERTAKER John H. Toadvine ADDRESS 142 Ostend St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88505 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88505

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Smith

(a) Residence No.... 554 Mosher St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-if married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Francis Hughes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Fanni Bluffert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Fannie Smith

(Address) 554 Mosher St

15- Filed JUL 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-7-24

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1924 to July 7, 1924

that I last saw her alive on July 7, 1924,

and that death occurred, on the date stated above, at 9-45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of colon

General Metastasis (Duration) yrs. 9 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL, 7/10/24

20-UNDERTAKER. David Easton — ADDRESS 916 Ca ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88506

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Simms

(a) Residence No. St. Elizabeth's Home St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 31, 1918 Unknown

7-AGE. 5 6 7
3 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Nume of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. William Simms

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12-MAIDEN NAME OF MOTHER. Darby Ennis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Hospital records

(Address) M.T.H.

15- Filed JUL 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1924 to July 8, 1924

that I last saw him alive on July 8, 1924,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and
Tuberculous Hip
(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis
(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) L. D. Thom, M. D.

7-9- 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Mt Auburn Cem	7/10/24
20-UNDERTAKER.	ADDRESS
Daniel Easter	916 Pa ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88507

CERTIFICATE OF DEATH.

31 D 88507

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Byczynski

(a) Residence No. 2600 Foster ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Wm. Byczynski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUL 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25, 1924 to July 8, 1924

that I last saw him alive on July 8, 1924

and that death occurred, on the date stated above, at 5.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Sputum, X-ray

(Signed) J. F. White M. D.

7-9-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary | DATE OF BURIAL, July 12, 1924

20-UNDERTAKER, John M. Weber | ADDRESS 1803 Bank St

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88508

HEALTH DEPARTMENT—CITY OF BALTIMORE (Batty) ✓

CERTIFICATE OF DEATH.

D 88508

1-PLACE OF DEATH Bay View Hospital 1 90 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Batty

(a) Residence No. 1519 Brevald St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Batty

6-DATE OF BIRTH (month, day and year) 1898

7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Batty

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mandy Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-(Informant) Bay View Hosp.

(Address).....

15-Filed JUL 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 12, 1924 to July 8, 1924

that I last saw h. in live on July 7, 1924

and that death occurred, on the date stated above, at 6.09 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) mos. 10 ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

Pyelitis, Uraemic (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Schmidt M. D.

, 19 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pleasant View Cem. DATE OF BURIAL, July 10 1924

20-UNDERTAKER, Samuel Hensley ADDRESS 1128 W. Baltimore

---

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 88509

D 88509 — REGISTERED NO.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1505 N Dallas ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Major Matthews

(Residence in Baltimore: No. 1505 N Dallas St.; 40 yrs., X mos. X da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 6 (Day), 1874 (Year)

7-AGE. 49 yrs. 8 mos. X ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Geo Matthews

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Harriet ?

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Mathews

(Address) 1505 N Dallas St.

15-

Filed....., 191.....

Registrar.

JUL 10 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, JULY (Month) 7 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JUL 5 1924 191, to JUL 6 1924 191, that I saw h/ IY alive on JUL 6 1924 191, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Dilatation Heart

(Duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Thr Disease Myo. Carditis

(Duration) X yrs. X mos. 2 ds.

(Signed) H H Decker M. D.

JUL 9 1924 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery — DATE OF BURIAL, July 10, 1924

20-UNDERTAKER Wm R G. Elliott — ADDRESS 1726 Eutaw and

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88510

CERTIFICATE OF DEATH.

D 88510

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Coleman

(a) Residence No. 604 W. Biddle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE, 53 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Florida

PARENTS.

10-NAME OF FATHER, James Coleman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Georgia

12-MAIDEN NAME OF MOTHER, Johanna Daley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Georgia

14- (Informant) Hospital Records

(Address) M.T.H.

15- JUL 16 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1923 to July 6 1924 that I last saw him alive on July 6 1924 and that death occurred, on the date stated above, at 4.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Terminal broncho-pneumonia (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) J. F. White, M. D.

7-7-, 1924 (Address) Municipal Tuberculosis

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem.	July 10 1924

UNDERTAKER. Samuel T. Hawley ADDRESS 1711 W. Biddle St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information is a PERMANENT RECORD. instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Cor.—1-12-23—M&T—100 Bks.

D 88511 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88511

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Pecker.

(a) RESIDENCE No. 403 N. Broarway. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? 16 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Eva Pecker.

6 DATE OF BIRTH (month, day, and year) Do not know 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	44	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Building wrecker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Julius Pecker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Frieda --------.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Eva Pecker. (wife)
(Address) 403 N. Broadway.

15 JUL 10 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Pelvis crushed about chest. Internal Injuries. Caught under falling wall. (duration) yrs. mos. ds.

Accidental Death.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

July 10., 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death? Accident E. E. Cor. Gay & Forrest Sts. July 9, 24

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Wash. Road DATE OF BURIAL July 11 1924

20 UNDERTAKER Jas. T. Lewis, ADDRESS 1439 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND, BALTIMORE CITY TO WIT:-

I hereby certify that on this 17th day of July, in the year 1924 before me the subscriber, a Notary Public of the State of Maryland, in and for Baltimore City aforesaid, personally appeared Yetta Pecker, also known as Eva Yetta Pecker and made oath in due form of law, that she is the widow of Samuel Pecker; and that the said Samuel Pecker was born on the 3rd day of April, 1880, and that at the time of his death, which occurred on July 9th, 1924, he was forty-four (44) years of age.

WITNESS MY HAND AND NOTARIAL SEAL.

Eva Yetta her x Pecker
Affiant mark

Jessie Myerberg
Notary Public

Israel Dorman Witness
Lebah Pecker Witness

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2915 W.Mosher St., 16 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Wieman,

(a) Residence No. 2915 W.Mosher St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: L.H.Wieman,

6-DATE OF BIRTH (month, day and year): Oct.8.1849

7-AGE: 74 yrs. 9 mos. 1 ds.

If LESS than 1 day, hrs. or min.:

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore

(State or Country): Md.

PARENTS.

10-NAME OF FATHER: John C.Jurgens,

11-BIRTHPLACE OF FATHER (city or town):

(State or Country): Germany

12-MAIDEN NAME OF MOTHER: Charlotta Greninger,

13-BIRTHPLACE OF MOTHER (city or town):

(State or Country): Germany

14-

(Informant): Geo.Wieman,

(Address): 2915 W.Mosher St.

15-

Filed JUL 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): JUL 9 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to July 9, 1924, that I last saw h.e alive on July 9, 1924, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dalrett, M. D.

JUL 10 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR ~~REMOVAL~~: New Cathedral DATE OF BURIAL: JUL 12 1924, 19..

20-UNDERTAKER: Geo W Little ADDRESS 2700 EDMONDSON AVE.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88513

D 88513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2001 E 31st (ST.,) (9) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Logan

(a) RESIDENCE NO. 2001 E 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ellen H Logan

6 DATE OF BIRTH (month, day, and year) Dec 15th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mary P Logan

(Address) 2001 E 31st st

15 Filed JUL 10 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to July 8, 1924,

that I last saw h[illegible] alive on July 8, 1924

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) about 1 year yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Consistent Jaundice

What test confirmed diagnosis? Enlarged Indurated Liver

(Signed) Hong Kyle, M. D.

July 9 1924 (Address) 1001 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 11th 1924

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88514

CERTIFICATE OF DEATH.

D 88514

REGISTERED No. 188-9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 9 WARD)

2-FULL NAME Albert A.Fischer

(a) RESIDENCE No. 807 Venable Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 5 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella N.Fischer

6 DATE OF BIRTH (month, day, and year) Feb.2 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto.Patrol &
(c) Name of employer Watchman Service Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John B.Fischer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma M.Meyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs.Emma M.Fischer
(Address) 913 Burgundy St.

15 Filed JUL 10 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Street Car accident
accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John Morrissey M. D.
(Coroner)

July 7th, 1924 (Address) 5632 Reloudan

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 10 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of information

Spec.—1-10-21—M&T—1500 Bks.

D 88515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Belmont ST., 9 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E Kirby

(a) RESIDENCE No. 1302 Belmont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~. (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ (or) ~~HUSBAND OF~~ WIFE of J. Edward Kirby

6 DATE OF BIRTH (month, day, and year) May 21 - 1856

7 AGE: Years 68 years; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Wm J Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Mary E Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant Wm M. Wilhelm

(Address) 214 Harford Ave

15 Filed JUL 1 0 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 24

17 I HEREBY CERTIFY, That I attended deceased from July 5 24, 19 ..., to July 9, 19 24

that I last saw h alive on July 8, 19 24

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis

Chr. Int. Neph.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. D. Fraser, M. D.

7-10 1924 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: July 11 1924

20 UNDERTAKER: Robt J Turner Sons — ADDRESS: 442 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88516

CERTIFICATE OF DEATH.

60-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland General Hosp ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Dietrich (Miss)

(a) RESIDENCE No. 1704 N. Washington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles F. Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Miss Ruth Dietrich

(Address) 1704 N. Washington St.

15 Filed JUL 10 1924, 19 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-1924

17

I HEREBY CERTIFY, That I attended deceased from 6-14-, 1924, to 7-8-, 1924, that I last saw her alive on 7-8-, 1924, and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Thyroid

(duration) 0 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Hyperthyroidism 3rd Broncho Pneumonia (3 days) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-5-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Young, M. D.

, 19 (Address) M. G. Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 12, 24

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88517 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88517

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2508 Denison St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Meister

(a) Residence No. 2508 Denison St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. 11 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: Single (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 6-1923

7-AGE, — yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Charles J. Meister

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Edna J. Robertson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Charles J. Meister

(Address) 2508 Denison

15- Filed....., 192.....

JUL 10 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 15 1924 to July 8 1924, that I last saw h— alive on July 8 1924, and that death occurred, on the date stated above, at 8308 m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ....yrs. ....mos. 23 ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(Duration) ....yrs. ....mos. 23 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Tibbitt, M. D.

July 8, 1924 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park | DATE OF BURIAL, 7/11/24

20-UNDERTAKER Geo. Weber & Son | ADDRESS 2503 Edmondson Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88518

CERTIFICATE OF DEATH.

90 D 88518

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6037 Falls Road ST., 27 (WARD)

2-FULL NAME James Randolph Shipley

(a) RESIDENCE NO. 6037 Falls Road ST., 27 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Shipley

6 DATE OF BIRTH (month, day, and year) Oct 4th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dyer Mater'l

(b) General nature of industry, business, or establishment in which employed (or employer) Finishing Factor

(c) Name of employer Fred Kahn

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Annie W. Fair, (Address) 6037 Washington

15 JUL 10 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1924, to July 9, 1924, that I last saw him alive on July 8, 1924, and that death occurred, on the date stated above, at 9.05 AM

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Enlarged Heart

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) William J. Scott, M. D.

(Address) 1119 W Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL July 11 1924

20 UNDERTAKER A B Marshall — ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88519

CERTIFICATE OF DEATH.

38 D 88519

1-PLACE OF DEATH D 88519

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bert E. Murrell

(a) RESIDENCE NO. 746 W. Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address) .....

15 JUL 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Syphillitic Hepatitis
(Aneurism Ascending &transverse aorta
Syphillis-U of M. March 1924) (Duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paul, M. D.
(Coroner.)

7/9/24, 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY — DATE OF BURIAL — 192

20 UNDERTAKER ..... ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

89

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 88520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88520

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1217 Wilcox Street, 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Crogan (Croghan)

(a) Residence No. 1217 Wilcox Street, Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 7-1921

7-AGE. 2 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Edward Crogan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Nora Barrett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Edward Crogan

(Address) 1217 Wilcox St

15- Filed ... 192 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 10-24

17- I HEREBY CERTIFY, That I attended deceased from July 5th 1924, to July 10 1924,

that I last saw h[illegible] alive on July 9th 1924,

and that death occurred, on the date stated above, at 1.9 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

about 14

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. M. Parker M. D

July 10th 1924 (Address) 1114 Hollins St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Catholic

DATE OF BURIAL, 7/12, 1924

20-UNDERTAKER Wm Cook

ADDRESS 502 E Nort[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88521 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88521

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 E. 33rd St.; 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gertrude Bates

(a) RESIDENCE. No. 715 E. 33 St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm. Bates

6 DATE OF BIRTH (month, day, and year) Dec 23, 1867

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Geo. Maybin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kezie Pelt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant (Address) Joseph Wagner 715 E 33rd

15 Filed JUL 10 1924 19.. Registrar H. A. Mc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to July 8, 1924, that I last saw h[illegible] alive on July 8, 1924, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests.

(Signed) J. M. Delcroft, M. D.

July 9 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 11, 19 24

20 UNDERTAKER: [illegible] — ADDRESS: 502 E. Monu[illegible]

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88522

CERTIFICATE OF DEATH.

185 D 88522

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Orkney Rd ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Johnson

(Residence in Baltimore: No. 509 Orkney Road St.; 14 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, [illegible] (Month) ..... (Day) 1859 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Madison

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Gunyon

(Address) 509 Orkney Rd

15 JUL 10 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jun 28 1924, to July 8 1924, that I saw h[illegible] alive on July 8 1924, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Shock following Injuries d
Shock following Injuries d
Stumach, accidental

(Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Senility.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. C. Boehm M. D.

July 9 1924 (Address) 5835 Forrest

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Zion Cem. DATE OF BURIAL, July 10 1924

20-UNDERTAKER David S Hamsley ADDRESS N Bdlch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88523

CERTIFICATE OF DEATH.

90 D 88523

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2024 E Preston St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Kraisser

(a) Residence No. 2024 E Preston St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred. Kraisser

6-DATE OF BIRTH (month, day and year) April 6

7-AGE. 58 yrs. 3 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Albert Schwartz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Ida Kunn

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). " "

14- (Informant) Helen Kraisser

(Address) 2024 E. Preston St

15. JUL 1 01924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9 1924

17. I HEREBY CERTIFY, That I attended deceased from June 25 1924 to July 9 1924

that I last saw h.. alive on July 9 1924

and that death occurred, on the date stated above, at 2.20 A. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

1924 (Address) 1010 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. July 12 1924

20-UNDERTAKER. Geo M. Frick & Son ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88524
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mount Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Eva Miller

(a) Residence No.... Mount Hope Retreat St., 28 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Miller

6-DATE OF BIRTH (month, day and year): May 9th 1851

7-AGE: 72 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore
(State or Country): Md

PARENTS.

10-NAME OF FATHER: Franz Bieder

11-BIRTHPLACE OF FATHER (city or town): Bavaria
(State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary A Belz

13-BIRTHPLACE OF MOTHER (city or town): Hessen
(State or Country): Germany

14- (Informant): Records of Mt Hope Retreat
(Address): Mt Hope Baltimore Md

15- Filed July 10 1924 ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 3rd, 1924, to July 9th, 1924, that I last saw h[illegible] alive on July 9th, 1924, and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis Cum
Cerebral Atherosma
abt (Duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary): Senile Psychosis
abt (Duration) 2 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

July 9th, 1924 (Signed) Frank J. Slaumey, M. D.
(Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, July 13 1924

20-UNDERTAKER: Geo M. Frank Son — ADDRESS 811 N. Avenue

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88525

CERTIFICATE OF DEATH.

45 D 88525

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2131 N. Calvert St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Jane Cecil

(a) Residence No. 2131 N. Calvert St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W City

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. J. Cecil

6-DATE OF BIRTH (month, day and year) Jany 26 1847

7-AGE. 87 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Henry H North

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Sarah A Hornes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary C. Cecil

(Address) 2131 N. Calvert St

15- JUL 10 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9 1924

17- I HEREBY CERTIFY, That I attended deceased from June, 19 21, to July 9, 19 24

that I last saw h.. alive on July 8, 19 24

and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank M. Stitt M. D.

July 11 1924 (Address) 2463 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem. | DATE OF BURIAL, July 11 1924

20-UNDERTAKER John O. Mitchell ADDRESS 2201 W Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88526

CERTIFICATE OF DEATH.

100-001

D 88526

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME David Feldman

(a) RESIDENCE No. 520 N. Curtis ST., 8E WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22 1923

7 AGE: Years — Months 9 — Days 16 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work +

(b) General nature of industry, business, or establishment in which employed (or employer) +

(c) Name of employer +

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER David Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Vasek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records, JOHNS HOPKINS HOSPITAL

15 Filed JUL 10 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1924, to July 9, 1924, that I last saw him alive on July 9, 1924, and that death occurred, on the date stated above, at 1200 M. m.

The CAUSE OF DEATH* was as follows:

Primary broncho pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. A. Wreck, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL July 11 1924

20 UNDERTAKER Frank Enoch & Son — ADDRESS W. North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88527.

CERTIFICATE OF DEATH.

9D 88527.
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2441 E. Monument St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary J. Flavin

(a) Residence No. 2441 E. Monument St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Flavin

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Thomas Humpal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) Joseph Flavin

(Address) 2441 E. Monument St.

Filed JUL 10 1924 By ROBERT R. KRAUTER, Registrar.
Social Record Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 9, 24

17- I HEREBY CERTIFY, That I attended deceased from May 1924, to July 8, 1924, that I last saw h.. alive on July 8, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Probably a few years.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 10, 1924 (Address) 2005 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, July 12, 1924

20-UNDERTAKER, Paul Enoch Son — ADDRESS 1906 Eastlon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 88528

CERTIFICATE OF DEATH.

D 88528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1317 W. Lanvale St. (ST.) 11 (WARD)

2-FULL NAME Grace Mc Henry Bowman

(a) RESIDENCE NO. 1317 W. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elwood L. Bowman

6 DATE OF BIRTH (month, day, and year) July 14th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smithburg Md.

PARENTS

10 NAME OF FATHER James Mc Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Hilderbrand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Smithburg Md.

14 Informant L. Elwood L. Bowman. (Address) 1317 W. Lanvale St

15 Filed JUL 1 01924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) July 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1924, to July 8th, 1924.

that I last saw her alive on July 8th, 1924, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam

(Signed) Geo. Lung Strayer M. D.

1924 (Address) 409 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/11 1924

20 UNDERTAKER Henry W. Means & Son

ADDRESS 805 N. Gilmor

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 88529

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 88529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 3819 Fernwood Ave ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Wonders

(Residence in Baltimore: No. 3819 Fernwood Ave St.; Unknown yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, Nov. 25, 1858 (Month) (Day) (Year)

7-AGE, 65 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Detective
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Cumberland Co Pa

PARENTS.

10-NAME OF FATHER, Daniel Wonders

11-BIRTHPLACE OF FATHER (State or Country), York Co. Pa

12-MAIDEN NAME OF MOTHER Sarah A Bellow,

13-BIRTHPLACE OF MOTHER (State or Country), Perry Co Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J R Swisher

(Address) 3819 Fernwood ave

Filed JUL 1 01924, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 9 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6/14, 1924, to 7/9, 1924, that I saw h.. alive on 7/8/24, 191..., and that death occurred, on the date stated above, at 1:15 a m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Farrell M. D.

7/9/24, 191... (Address) 623-S-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Carlisle Pa — DATE OF BURIAL, July 11., 1924

20-UNDERTAKER Balsbaugh & Penn — ADDRESS 715 Liberty St

John F Denny

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88530

CERTIFICATE OF DEATH.

80 D 88530

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 454 W. Hamburg ST., 17 WARD)

2-FULL NAME George H. Maurice

(a) RESIDENCE NO. 454 W. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	3	2.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER G. H. Maurice

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Margt Shanklin

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant G. H. Maurice
(Address) 454 W. Hamburg

15 Filed JUL 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

, 1924 (Address) 362 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	July 11 1924
20 UNDERTAKER	ADDRESS
Fred C. Sasse & Sons	Gilbert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8853½

CERTIFICATE OF DEATH.

127-802 D 8853½

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 106 Main St. Hillsdale 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rauson T. Bryant

(Residence in Baltimore: No. 106 Main St. Hillsdale Balto St.; 49 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, February 25th (Month), 1856 (Day) (Year)

7-AGE, 68 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, William Bryant

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha J. Bryant

(Address) Hillsdale, Maryland

15- JUL 10 1924, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4th 1924, to July 8th 1924, that I saw h[illegible] alive on July 8th 1924, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease
and Hardening of Liver

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Brights

Disease (Duration) ... yrs. 2 mos. ... ds.

(Signed) Chas. Y. Everhart M. D.

7/9, 1924 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	July 11, 1924
20-UNDERTAKER	ADDRESS
Joseph B Cook	1003 N. Balto

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88532

CERTIFICATE OF DEATH.

D 88532

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 767 W Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh. P. McNeill

(a) Residence No. 767 W Lexington St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 5 1878

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, P McNeill.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Catherine McConnell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Rose McNeill

(Address) 952 N. Washington st

15- JUL 1 0 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 10 1924

17- I HEREBY CERTIFY, That I attended deceased from July 3 1924 to July 10 1924

that I last saw h.. alive on July 5 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uraemia N.B.

Contributory Cystitis Secondary

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cmty. DATE OF BURIAL. July 11 1924

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88533

CERTIFICATE OF DEATH.

129

D 88533

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 620 Crawford St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna K. Wolfe

(a) Residence No. 620 Crawford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of C. H. Wolfe

6-DATE OF BIRTH (month, day and year) 3-20-1855

7-AGE 69 yrs. 3 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ax Home

(b) General nature of industry, business, or establishment in which employed (or employer) HH

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country) Balto Md

PARENTS:

10-NAME OF FATHER [redacted]

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER, [illegible] Wilson

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Ireland

14-Informant Clarena E. Wolfe

(Address) 1627 N. Broadway

15-Filed JUL 1 01924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9-24

17- I HEREBY CERTIFY, That I attended deceased from June 19 24 to July 9 19 24

that I last saw h alive on July 9 19 24

and that death occurred, on the date stated above, at 9 30 P. M.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hamm M. D

7-10 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Dulls Cemetery DATE OF BURIAL 7/12 1924

20-UNDERTAKER Wm Cook ADDRESS 502 E Nor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88534

CERTIFICATE OF DEATH.

D 88534

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 E. Clement St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William E. Potee

(a) Residence No..... 508 E. Clement St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 26. 1901

7-AGE, 22 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, William H. Potee

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Marie L. Schepers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Europe

14-

(Informant)..... Wm. H. Potee

(Address)..... 505 E. Clement St.

15-

Filed..... JUL 10 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9 1924

17- I HEREBY CERTIFY, That I attended/deceased from Mar 26, 19 24, to July 9, 19 24

that I last saw h[illegible] alive on July 9, 19 24

and that death occurred, on the date stated above, at 6.35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Phys & Exam

(Signed) W. McElroy, M. D.

7/10, 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a.a.Co. DATE OF BURIAL, July 12, 19 24

20-UNDERTAKER, Margaret A. Flynn ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88535 .

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 ✓ D 88535

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 673 E. Clement St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. McEvoy

(a) Residence No. 673 E. Clement St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John J. McEvoy

6-DATE OF BIRTH (month, day and year) Aug 20, 1853

7-AGE, 70 yrs. 10 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... (37)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John McMullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Parsons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) John McEvoy

(Address) 673 E. Clement

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

OCT 10 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-7-24

17- I HEREBY CERTIFY, That I attended deceased from 7-3-24, 19.., to 7-7-24, 19..

that I last saw h.. alive on 7-7-24, 19..

and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Philip B. Fowler, M. D.

7-8-, 19.. (Address) 1432 William St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, July 11, 19.24

20-UNDERTAKER, Margrett S. Flynn — ADDRESS 1422 Light St

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 88536 — PLACE OF DEATH

74 D 88536 — REGISTERED NO. C

CITY OF BALTIMORE (No. 2300 Fairmount Ave. St. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME DORA SHUHAM

(Residence in Baltimore: No. 2300 Fairmont Ave., St. 32 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: white.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow.

6-DATE OF BIRTH: July (Month) — (Day), 1850 (Year)

7-AGE: 74 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Mordecai Shuhan

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Tobie (Shuhan)

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Shuham

(Address) 2300 E Fairmount Ave

15 JUL 10 1924

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month), 10 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920. to July 8 1924.

that I saw her alive on July 8, 1924.

and that death occurred, on the date stated above, at 9a, m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Cerebral Hemorrhage,

Chronic Myocarditis

(Duration) 4 yrs. — mos. — ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed), David D. Bracht, M. D.

July 10, 1924. (Address) 3420 Auchentoroly Ter.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2300 E Fairmount Ave

19-PLACE OF BURIAL OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: July 11, 1924

20-UNDERTAKER: Sol Levinson

ADDRESS 1127 E Balto st

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88537 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-801

D 88537.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 628 W. Saratoga St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Angelo Florio so

(a) Residence No. 628 W. Saratoga St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Concetta.

6-DATE OF BIRTH (month, day and year) 10/13-1862

7-AGE. 61 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Owner

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER, Salvatore Florio

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Teresa Giardina

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

11- (Informant) Kinard Florio

(Address) 628 W. Saratoga st.

15- JUL 1 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-8-24

17- I HEREBY CERTIFY, That I attended deceased from 5-8 1924 to 7-8 1924

that I last saw h.. alive on 7-8 1924

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

Cardio Renal, Hypertension

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(Duration) yrs. 13 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Not

What test confirmed diagnosis? Clinical

(Signed) S. Demarco M. D

7-9- 1924 (Address) 168 Linden ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery DATE OF BURIAL. July 11 1924

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88538 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nollmeyer

(a) RESIDENCE NO. 2120 Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) July 9 24

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER George Nollmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER Jessie Offenbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Amsterdam Holland

14 Informant: George Nollmeyer (Address) 2120 Biddle

15 Filed JUL 11 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1924

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1924, to July 10, 1924, that I last saw h— alive on July 10, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

a Malestrom

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Reamer, M. D.

19 Address 801 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 16 1924
20 UNDERTAKER	ADDRESS
Henry Koch & Son	1304 E. Eager St

Spec. 1-10-21 M&T 1500 Blks.

(Louisa Waters)

D 88539 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D 88539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Fenby Hall ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Waters

(a) RESIDENCE NO. 920 Fenby Hall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Waters

6 DATE OF BIRTH (month, day, and year) Jan 4 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Ross

11 BIRTHPLACE OF FATHER (city or town) Bethlehem Ms
(State or country)

12 MAIDEN NAME OF MOTHER Alice Sprigs
Alice Griggs

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Estelle Ross (Sister)
(Address) 617 Green St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1924

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to July 9, 1924,

that I last saw her alive on July 8, 1924,

and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) yrs. [illegible] ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Avery, M. D.

, 19 (Address) 16 Eutaw Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 12 1924

20 UNDERTAKER H. W. Brown & Son

ADDRESS 105 W. Monte

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 1 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Irwin O. Ridgely)

D 88540

CERTIFICATE OF DEATH.

X45

D 88540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irwin O. Ridgley

(a) RESIDENCE NO. Catonsville Md ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Oliver B Ridgley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mrs. Harriet Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record

(Address)

15 Filed JUL 1 1924 G.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/24

17 I HEREBY CERTIFY, That I attended deceased from 7/11/24, 19..., to 7/11/24, 19...

that I last saw h— alive on 7/11/24, 19...

and that death occurred, on the date stated above, at 6:03 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Hillary, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Chapel

DATE OF BURIAL July 13 1924

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

Spec.—1-10-21—M&T—1500 Bks.

D 8854 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8854

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Wansley St. 12 12 WARD)

2-FULL NAME Daniel Turner

(a) RESIDENCE NO. 418 Wansley St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Turner

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE: Years: About 80 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: Norton Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Cockrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cockrum

14 Informant (Address): Julia Turner 418 Worsley St

15 Filed JUL 11 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23 1924, to July 9th 1924, that I last saw h.. alive on July 9 1924, and that death occurred, on the date stated above, at 2.35 PM

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Cardiac failure

(duration) ? yrs. ? mos. 16 ds.

CONTRIBUTORY (Secondary) Age and hard work (duration) 80 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Ed H Hall, M. D.

, 19 (Address) 4166 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: July 11 1924

20 UNDERTAKER: Samuel Brumley & Wyatt | ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88542

CERTIFICATE OF DEATH.

101 - D 88542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Buckles

(a) RESIDENCE No. 1416 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Henry Buckis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Crotamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Record

(Address)

15 Filed JUL 11 1924 H. Carr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/24 19

17 I HEREBY CERTIFY, That I attended deceased from 7/5/24, 19..., to 7/9/24, 19...,

that I last saw h— alive on 7/9/24, 19...

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. W. Gilly, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7/12 24
20 UNDERTAKER	ADDRESS
George A Farley Sutton &	Forgette

D 88543

D 88543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C 113

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Scarretti

(Residence in Baltimore: No. 1401 Division St. St.; yrs. 2 mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Single

6-DATE OF BIRTH: March (Month) 8 (Day) 1924 (Year)

7-AGE: yrs. 9 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Eckhart Md.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown.

12-MAIDEN NAME OF MOTHER: Willie Scarretti

13-BIRTHPLACE OF MOTHER, (State or Country): Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Schaffer

Juvenile Court Cumberland Md.

15- Filed JUL 11 1924 H. Ann Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5/24 (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Probably) Toxemia - Gastro-intestinal Ingigestion

(Autopsy at Hopkins-nothing definite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Pales M. D. (Coroner.)

July 11/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: January 14 1924

20-UNDERTAKER: Martin Tookey Son ADDRESS 1220 N. North Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88544

D 88544

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

2-FULL NAME Joseph Parks

(a) RESIDENCE No 1125 Bolton St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 1/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ruther Short

13 BIRTHPLACE OF MOTHER (city or town) (State or country) CharlesCO. Md

14 Informant Mrs R.M Elliott
(Address) 1725 Ashland Ave

15 JUL 11 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Larygeal Diphtheria

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Collins, M. D.
(Coroner)

7/11/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters cemetery	July 11th 1924
20 UNDERTAKER	ADDRESS
Mrs R. A Elliott	1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88545

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 88545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 219 Hawthorne Road Roland Park WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Herman Ireland

(Residence in Baltimore: No. 219 Hawthorne Road Roland Park St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.): Married

6-DATE OF BIRTH: May (Month) 11 (Day) 1864 (Year)

7-AGE: 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance Business
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Kent Co Md

PARENTS.

10-NAME OF FATHER: John H. Ireland

11-BIRTHPLACE OF FATHER (State or Country): Kent Co Md

12-MAIDEN NAME OF MOTHER: Mary Ringgold Comegys

13-BIRTHPLACE OF MOTHER (State or Country): Kent Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ireland

(Address) 219 Hawthorne Road R.P.

JUL 11 1924 ROBERT R. KRAUTER,
....., 1924 Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 10 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun shot Wound
through Head
Suicide

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) John A. Morresson M. D.
(Coroner.)

July 10 1924 (Address) 3632 Roland Av

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Elkton Cecil Co Md

DATE OF BURIAL, July 12th 1924

20-UNDERTAKER: Henry H. Jenkins Son & Co

ADDRESS: Orchard & Fayette St

Form—12-23-21—E.P.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88546

CERTIFICATE OF DEATH.

74-001

D 88546
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 N. Lakewood Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia C. Turner

(a) Residence No. 508 N. Lakewood Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Thomas Turner

6-DATE OF BIRTH (month, day and year): Feb. 15, 1854

7-AGE: 70 yrs. 4 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS:
10-NAME OF FATHER: John Zimmerman
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Annie Schubert
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Mrs William L. Turner
(Address) 508 N. Lakewood Ave

15- JUL 11 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1st, 1924 to July 10th, 1924 that I last saw her alive on July 10th, 1924 and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation.

(Signed) Wm Conrad Bode M. D.
, 19 (Address) 1900 Maryland Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: July 12, 1924

20-UNDERTAKER: H. Sander Sons ADDRESS: 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88547.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88547

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Joseph's Hosp ST., 21 WARD)

2-FULL NAME Tillie Schneider

(a) RESIDENCE NO. 1203 W. Cross ST., 21 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Adam Schneider

6 DATE OF BIRTH (month, day, and year) March 14th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adam Schneider
(Address) 1203 W. Cross St.

15 Filed JUL 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/24

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to July 10, 1924.
That I last saw her alive on July 10, 1924,
and that death occurred, on the date stated above, at 2.45 P. m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Renal Calculus - Pyonephrosis 5 Years
Pennsylvania Abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1203 W. Cross St.
Did an operation precede death? yes Date of 7/5/24
Was there an autopsy? no
What test confirmed diagnosis Physical Evidence
(Signed) Geo. B. Gilbert, M. D.
, 19 (Address) St. Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 7/14 1924

20 UNDERTAKER George Lembach & Son — ADDRESS 647 W Pratt St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88548

CERTIFICATE OF DEATH

D 88548

1-PLACE OF DEATH Vol. of America Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. 418 S. Lexington St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Comra

(a) RESIDENCE. No. Hunterstown, Bald WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Comra

6 DATE OF BIRTH (month, day, and year) 3/28/1864

7 AGE 60 Years Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Market Seller

(b) General nature of industry, business, or establishment in which employed (or employer) Not Employed

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs Elizabeth Comra
(Address) 1712 E Lafayette Ave

15 JUL 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to July 10, 1924, that I last saw him alive on July 10, 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure test & Urine Analysis

(Signed) Edward Bowers, M. D.

, 19 (Address) 418 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 12 1924

20 UNDERTAKER John Merrick

ADDRESS 2008 Eutaw

D 88548

K. I. S. A.

K O D A K

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88549

CERTIFICATE OF DEATH.

D 88549 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ridge Rd & Windsor Mill Rd Ward)

2-FULL NAME Anna C. Hollenshade

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Ridge Rd & Windsor Mill Rd St.) 74 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. Jan (Month) 7 (Day) 1854 (Year)

7-AGE. 70 yrs. 6 mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Louis Ende

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dorothy Wost

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs T Hollenshade

(Address) Hagerstown Md

JUL 11 1924 Filed 191

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 10th (Day), 1924 (Year)

I HEREBY CERTIFY, That I attended deceased from July 12th 1921, to July 10th 1924, that I saw h[illegible] alive on June 25th 1924, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Lesions of Heart

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(Duration) 3 yrs. mos. ds.

(Signed) Geo. Y. Everhart M. D.

July 11th, 1924 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Mary's Cemetery DATE OF BURIAL. July 14, 1924

20-UNDERTAKER Hampson & Lutz ADDRESS 1203 N. Broadway

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88550

CERTIFICATE OF DEATH.

X 181-009 D 88550

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Anerety Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Ruth Jackson-

(a) RESIDENCE NO. Belair ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 08-28-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	8.	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer —

9 BIRTHPLACE (city or town) Belair
(State or country) Md

PARENTS

10 NAME OF FATHER Norman Jackson

11 BIRTHPLACE OF FATHER (city or town) Frankville
(State or country) Md

12 MAIDEN NAME OF MOTHER Alen McMullen

13 BIRTHPLACE OF MOTHER (city or town) Street
(State or country) Md

14 Informant Norman Jackson
(Address)

15 Filed JUL 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Possibly Phosphorous Poison

(duration) ..... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Jaundice Possibly

(duration) ..... yrs. mos. 10 ds.

(Signed) T K Gonnuch, M. D.
(Coroner.)

July 11, 1924 (Address) 1170 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fork Md	July 14 1924
20 UNDERTAKER	**ADDRESS**
Foster	Belair, Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8855 1

CERTIFICATE OF DEATH.

1 188-803

D 8855 1

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayview Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Freund

(Residence in Baltimore: No. 708 S. Decker ave. St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 7 (Day) 1890 (Year)

7-AGE: 34 yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of Industry, business, or establishment in which employed (or employer): Pullman Co.

9-BIRTHPLACE, (State or Country): Salt Lake City

PARENTS.

10-NAME OF FATHER: Charles Freund

11-BIRTHPLACE OF FATHER, (State or Country): Salt Lake City

12-MAIDEN NAME OF MOTHER: Jennie Hilbert

13-BIRTHPLACE OF MOTHER, (State or Country): Salt Lake City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Freund

(Address) 139 E. Oxford St.

15. Filed JUL 12 1924 19.. Registrar. [signature]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, Contusions Chest, Auto-mobile accident

Collision (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Fenton M. D. (Coroner)

July 11 1924 (Address) 701 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)
At place of death 1 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Philadelphia Pa. & Rd.

Former or usual residence 708 S. Decker ave.

19-PLACE OF BURIAL OR REMOVAL: Mount Olivet — DATE OF BURIAL: July 14 1924

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88552 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 88552

CERTIFICATE OF DEATH.

6 80

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2315 Jefferson St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John E. White

(a) Residence No. 2315 Jefferson St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 4 - 1924

7-AGE, ... yrs. 2 mos. 11 ds. IF LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John E. White

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Dibbern

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Charles Dibbern

(Address) 2315 Jefferson St

15- Filed ..... 19.....

Registrar.

JUL 7 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 11 24

17- I HEREBY CERTIFY, That I attended deceased from July 11 ....., 19.24., to July 11 ....., 19.24.,

that I last saw h.... alive on July 11 ....., 19.24.,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... yrs. ..... mos. 2 hrs ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. D. Kluge, M. D.

, 19 (Address) 836 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. | DATE OF BURIAL: July 14 1924

20-UNDERTAKER: Mrs C. Miller | ADDRESS: 2330 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88553

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Loney Lane & Federal St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert B. Horton

(a) RESIDENCE NO Loneys Lane & Federal St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter 63
(b) General nature of industry, business, or establishment in which employed (or employer) New York Times
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Harry P. Horton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Finch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Emma D. Horton
(Address) Loney Lane & Federal St

15 Filed JUL 12 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Haller (Coroner.), M. D.

7/12/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 14 1924
20 UNDERTAKER	ADDRESS
Wm. J. Hartley	815 N. Washington

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88554

CERTIFICATE OF DEATH.

90 D 88554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 E. Preston St ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick C. Dunker

(a) RESIDENCE NO 2413 E.Preston St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Dunker

6 DATE OF BIRTH (month, day, and year) May 28/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Wm. Suchtig
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Caston Dunker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Augusta Dunker (Address) 2413 E. Preston St

15 Filed ..... 192.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv. Insuffieiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis- Senility

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Wallis, M. D.
(Coroner.)

7/11/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	July 12 192 4
20 UNDERTAKER	ADDRESS
Chas C. Butler	2337 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88555

CERTIFICATE OF DEATH.

129 D 88555

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 S Carey ST., 1 WARD)

2-FULL NAME Cora J Meyer

(a) RESIDENCE NO. 35 S Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Entwisle deceased

6 DATE OF BIRTH (month, day, and year): Jan 2. 1864

7 AGE: Years 60 Months 6 Days ____ If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

837

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Sagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Wash Co Md

12 MAIDEN NAME OF MOTHER: Ellen K Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Charles F. Meyer (Address) 35 S. Carey St

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1924, to July 9, 1924.

that I last saw her alive on July 9, 1924

and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ____ yrs. ____ mos ____ ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) 2 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of 5/3/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Alan Deming, M. D.

, 19 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK — DATE OF BURIAL 7/12 1924

20 UNDERTAKER: ROBT. BROOKS SON — ADDRESS COR CALHOUN HOLLINS

Spec—12-23-21—E.B.R.S.—400 Bks.

(Annie Sears)

D 88556 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 88556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 224 N. Carlton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Annie Sears.

(a) Residence No. 224 N. Carlton St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Sears

6-DATE OF BIRTH (month, day and year) Sept. 6 1882

7-AGE, 41 yrs. 10 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Godfrey Tucker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Natalie Banks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Benjamin Sears (Address) 224 N. Carlton St

15- Filed JUL 12 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 10 24

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 10, 1924, that I last saw h[er] alive on June 9, 1924, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Jane E. Rapine M. D.

7/12, 1924 (Address) 1002 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Cemetery DATE OF BURIAL, July 12, 1924

20-UNDERTAKER, Samuel Handley ADDRESS 1918 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88557

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Reinhardt

(a) RESIDENCE. No. 1410 Ward ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Louis Nutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Municipal Hospital Record

(Address)

Filed JUL 12 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-9, 1924, to 7-10, 1924

that I last saw her alive on 7-9, 1924

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Vegetative Endocarditis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Brace, M. D.

7-11-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 12 24

20 UNDERTAKER ADDRESS

Edmund Hendy Mt. Olive

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Magnuss, 1206 E Preston St

D 88558

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 North Bradford St., 8 Ward) 14001 Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Biscoe

(a) Residence (Usual place of abode) No. 1607 North Bradford St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Biscoe

6-DATE OF BIRTH (month, day and year) Nov. 20. 1864

7-AGE, 59 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS:

10-NAME OF FATHER Gustus Mulla

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) George Biscoe

(Address) 1607 North Bradford St

15- ...ted ..... 192.. L L S Registrar.

JUL 12 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 10. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 19 24 to July 10 19 24

that I last saw h~~er~~ alive on July 10 19 24

and that death occurred, on the date stated above, at 3.45 p.m.,

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

from arteriosclerosis.

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. L. Magnuss M. D

7, 11, 1924 (Address) 1206 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, July 14, 1924

20-UNDERTAKER, J. M. Cook — ADDRESS, 562 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 207 Patapsco Street W Westport Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jemima Cooper

(a) Residence No. 207 Patapsco St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thos V. Cooper

6-DATE OF BIRTH (month, day and year) Sept 18 1858

7-AGE, 63 yrs. 10 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ex Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Tom Rock Va

PARENTS.

10-NAME OF FATHER, Tom Mac Cubbins

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Elizabeth MacAfee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14-

(Informant) Thos V. Cooper

(Address) 207 Patapsco Street

15-

Filed JUL 12 1924 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 11 1924

17- I HEREBY CERTIFY, That I attended deceased from June 11th 1924 to July 11th 1924

that I last saw h.. alive on July 11th 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 14 ds.

CONTRIBITORY (Secondary) Carcinoma of Stomach (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J E Boulton M. D.

7/11/24 19 (Address) 3909 Gouverneur Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park

DATE OF BURIAL, July 14 1924

20-UNDERTAKER, Wm Cook

ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 88560

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST.: No WARD)

2-FULL NAME William Reps

(a) RESIDENCE. NO. Bay View Asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed JUL 12 1924 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-1 1924 to 7-9 1924

that I last saw him alive on 7-9 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ob.

(Signed) Claude C. Bruce M. D.

7-11 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL July 13 1924

20 UNDERTAKER Chas. H. Johnson ADDRESS 467 N. Carolina St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 8856F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8856F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2738 E Baltimore St., 6 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William John Bosse

(a) Residence No. 2738 E Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 18-1924

7-AGE, ...yrs. ....mos. 23 ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm R Bosse

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Barbara Mengel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Tom L Bosse

(Address) 2738 E Baltimore

15- Filed JUL 12 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 11-1924

17- I HEREBY CERTIFY, That I attended deceased from June 18 1924 to July 11 1924

that I last saw him alive on July 11 1924

and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmund Lee M. D.

July 11, 1924 (Address) 4 E Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jul 12 1924

20-UNDERTAKER, Wendell Dypert — ADDRESS 378 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 88562 HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 88562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Millholland

(a) Residence No. 1704 Halbrook St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Millholland

6-DATE OF BIRTH (month, day and year) 3/12/1869

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " "

14-

(Informant) Mrs. Catherine Millholland

(Address) 1704 Halbrook Street

15-

JUL 12 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/11/24

17- I HEREBY CERTIFY, That I attended deceased from 1/8 1924, to 7/11 1924,

that I last saw h[illegible] alive on 7/11 1924,

and that death occurred, on the date stated above, at 5.15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/2/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H W Harper, M. D

, 19 (Address) Glaque Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL, 7/14/, 1924

20-UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88563

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 E. Lezington ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Lee Flippans

(a) RESIDENCE No. 1213 E. Lezington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Aug 10/1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Privat family
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Tasco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marion Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Lillian Robinson
(Address) 1213 E. Lezington

15 JUL 12 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilatation

(Acute Indigestion)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) possibly Leuetic (duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. H. Pack, M. D.
(Coroner.)

7/12/24 192 (Address) 508E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loshing Cemetary	July 12 1924
20 UNDERTAKER	ADDRESS
Mrs. R. A. Ellick	1225 Ashland ave

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88564

CERTIFICATE OF DEATH.

12 D 88564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Lindun Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence H Powell

(a) RESIDENCE No. 823 Lindun Ave WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Powell

6 DATE OF BIRTH (month, day, and year): Dec 31, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber 070

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Susie Powell
(Address) 823 Lindun Ave

15 Filed JUL 12 1924, 19.... Registrar GLS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 9th 1924, to July 9th 1924.

that I last saw h.. alive on July 9th 1924

and that death occurred, on the date stated above, at 3:40 PM.

The CAUSE OF DEATH* was as follows:

Uremia
Poisoning

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Allen Ellis, M. D.

(Address) 912 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon

DATE OF BURIAL 7/12/24

20 UNDERTAKER: Paul Harbin

ADDRESS 976 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTRATION RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88565 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88565

CERTIFICATE OF DEATH. X 197

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 904 N. Eutaw ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Brown

(a) RESIDENCE No. 1324 W. Culloh St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) N. W. Dist. Police Station.

15 Filed JUL 12 1924 Registrar

209

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said au (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Pistol shot of head.

(duration) ..... yrs. ..... mos. ..... ds.,

CONTRIBUTORY (Secondary) Homicide

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D. (Coroner.)

July 9, 1924 (Address) 28 Exeter Hall Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY — DATE OF BURIAL JUL 10 1924

20 UNDERTAKER — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 88566

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 620 W Lanvale St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Hayes

(a) Residence No. 620 W-Lanvale St., Ward.....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~Single~~, Married, ~~Widowed~~ or Divorced. (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Rachel Hayes

6-DATE OF BIRTH (month, day and year) April 15 1872

7-AGE. 52 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Club

9-BIRTHPLACE (city or town) (State or Country), Rich. Va.

PARENTS.

10-NAME OF FATHER, Jas Hayes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Rich. Va.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Rich. Va.

14-

(Informant) Rachel Hayes

(Address) 620 W. Lanvale st

15-

JUL 1 31924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 10-24

17- I HEREBY CERTIFY, That I attended deceased from June 30- 1924 to July 10 1924

that I last saw h[illegible] alive on July 10 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bright Disease & Complication Disease

(Duration) yrs. 3 mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. L. W. Kennard M. D.

7-11 1924 (Address) 708 Esson St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Lookout	7/14 1924
20-UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 E. Mad st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88567

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women Hospital St., 1 WARD)

2-FULL NAME Rachael Tyler Chambers

(a) RESIDENCE NO. Lodge Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Chambers

6 DATE OF BIRTH (month, day, and year) May 23 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Albert Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Polly Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant James E. Chambers
(Address) Easton Pa.

15 Filed JUL 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of left hip accidental (fell in bathroom down stairs) (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 2 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

July 12 1924 (Address) 2802 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Women Hospital.
At place of death yrs., mos., 10 ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Lodge, Va.

Former or usual residence Lodge, Va.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C	July 12 1924
20 UNDERTAKER Wm. J. Tickner & Sons	ADDRESS N. Y. Pa

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88568

CERTIFICATE OF DEATH.

D 88568
1-PLACE OF DEATH

198 REGISTERED NO. D 88568

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Gresham

(a) RESIDENCE NO 1427 Eastern Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	w col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Sept/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Repairer
(b) General nature of industry, business, or establishment in which employed (or employer) Bicycles & motor cycles
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Atlanta Ga.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Georgia Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rev. E.E. Johnson
(Address) 1426 Eastern Ave

15 Filed JUL 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis-Stab wound by John carrington-Homocide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Pallen, M. D.
(Coroner.)

7/12/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlanta Georgia — DATE OF BURIAL 7/12 192

20 UNDERTAKER George J. Ruth — ADDRESS 1730 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88569
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

D 88569
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 1339 Hanover ST. 23 WARD)

2-FULL NAME Elara Virginia Ruhland

(a) RESIDENCE No. 1339 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Augustus Ruhland

6 DATE OF BIRTH (month, day, and year) Jan 23 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	18	

8 OCCUPATION OF DEACEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Permilla Bassett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Permilla Schlipferling
(Address) 1339 Hanover St

15 Filed JUL 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-1924

17 I HEREBY CERTIFY, That I attended deceased from July 7-, 1924, to July 11, 1924, that I last saw her alive on July 11-, 1924, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) C. J. Buxton, M. D.

7/11, 1924 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	July 14 1924
20 UNDERTAKER E. Schloman & Son	ADDRESS 1039 Hanover st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88570

CERTIFICATE OF DEATH.

74-001 ✓

D 88570
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 Lloyd St. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Yale Binder

(a) Residence No. 129 Lloyd St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Abraham Binder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Gilbert Binder

(Address) 129 Lloyd St

15- JUL 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12 24

17- I HEREBY CERTIFY, That I attended deceased from July 9th, 1924, to July 12th, 1924, that I last saw h. alive on July 11th, 1924, and that death occurred, on the date stated above, at 7.44 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Adams, M. D.

July 12, 1924 (Address) 360 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rising Sun — DATE OF BURIAL, 7/13, 1924

20-UNDERTAKER, S. Levinson & Bro — ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88571

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

51

REGISTERED NO. D 88571

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 21st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Cohen

(a) RESIDENCE No. 335 Gregory Ave, ~~Bm~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. 16 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Cohen

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 26 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Jack Lewis 1439 E Baltimore St

15 Filed JUL 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to July 12, 1924, that I last saw h alive on July 12, 1924, and that death occurred, on the date stated above, at 7:45 A.m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiac disease.

Pericarditis with effusion (duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Wm Lloyd Finla M. D.

(Address) (Univ.) Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem | DATE OF BURIAL: July 13 1924

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88572

CERTIFICATE OF DEATH.

12D 88572

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Ulman Ave ST.: 15 WARD)

2-FULL NAME Milton K. Baum

(a) RESIDENCE. No. 2600 Ulman Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Delia Baum

6 DATE OF BIRTH (month, day, and year): Aug 12 1863

7 AGE — Years: 61 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (Retired Grocer)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Kirshman Baum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jack Lewis
(Address) 1439 E Baltimore St

15 Filed JUL 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1923 to July 10, 1924 that I last saw h... alive on July 10, 1924 and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Eichenlaub M. D.

July 12 1924 (Address) 1142 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bath Hebrew Cem DATE OF BURIAL: July 12 1924

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88573 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 20 Spring Ave. Raspeburg Ward) 16 57 D 88573 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth E. Schlegel

(a) Residence No. 20 Spring Ave Raspeburg St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Schlegel

6-DATE OF BIRTH (month, day and year) April 10, 1847

7-AGE. 77 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Schwartz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Goetz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Henry Hevas

(Address) 3108 Gaithson Bldg.

15- JUL 1 31924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 11, '24

17- I HEREBY CERTIFY, That I attended deceased from May 17 1924 to July 11 1924

that I last saw h[illegible] alive on July 11 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Albert G. Webster M. D.

1/12/25 19 (Address) 7031 Belair Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	July 14, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander's Sons	1710 Fleet St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88574

CERTIFICATE OF DEATH.

128 D 88574

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901- Guilford Ave ST.: 12 WARD)

2-FULL NAME Frederick Menkel

(a) RESIDENCE. No. 2901- Guilford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna B. Menkel

6 DATE OF BIRTH (month, day, and year) Mar. 11- 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56		4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Louisa Opfa
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna B. Menkel
(Address) 2901 Guilford Ave

15 Filed JUL 13 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11/24

17
I HEREBY CERTIFY, That I attended deceased from May 25, 1924, (to July 11, 1924, that I last saw him alive on July 11, 1924, and (that death occurred, on the date stated above, at 10.1 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hospital -

(Signed) N. L. Dashiell, M. D.

19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 14 24
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88575

CERTIFICATE OF DEATH.

X 49 D 88575

JOHNS HOPKINS HOSPITAL.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ray

(a) RESIDENCE NO. Susquehanna Ave ST., Towson. Md

(Usual place of abode) WARD

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec. 5th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer's Son

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Johanna Nau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to July 11, 1924, that I last saw him alive on July 11, 1924, and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - cerebellar and brain stem - cystic glioma - locally malignant

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Post operative shock

(duration) ..... yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 10 11

Was there an autopsy? Held.

What test confirmed diagnosis? Operation

(Signed) H. R. Krauter M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presb. Cemetery Govans

DATE OF BURIAL: July 14 1924

20 UNDERTAKER: John Burns Sons

ADDRESS: Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88576

CERTIFICATE OF DEATH.

D 88576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 E Eager ST., 10 WARD)

2-FULL NAME John J. Metz

(a) RESIDENCE No. 1214 E Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdelena M. Metz

6 DATE OF BIRTH (month, day, and year) Oct. 13 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	83	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER John Metz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Kn (State or country)

14 Informant Mr. Frank Metz

(Address) 1214 E Eager St

15 JUL 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17th 1924, to July 11th 1924, that I last saw h[illegible] alive on July 11th 1924, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

Contributory Cachexia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm R Glover, M. D.

(Address) 1301 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemty	July 1924
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E Eager St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88577

CERTIFICATE OF DEATH.

188-D 88577

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Declared dead at St. Joseph Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick S.Cullen

(a) RESIDENCE NO 1639 E. Eager St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther T.Cullen

6 DATE OF BIRTH (month, day, and year) Feb. 7/1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Repair 03

(b) General nature of industry, business, or establishment in which employed (or employer) Train -Penna R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westernport, Md

PARENTS

10 NAME OF FATHER Patrick Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Esther T.Cullen

(Address) 1639 E. Eager St

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar

JUL 13 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-struck by Penna. train at Patterson Pk. Ave & Eager & thrown to street below. (accident)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Bowers, M. D.

(Coroner.)

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richwood Cemetery — DATE OF BURIAL July 15 1924

20 UNDERTAKER Henry Hood & Son — ADDRESS 1015 E. Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88578

CERTIFICATE OF DEATH.

51, D 88578

REGISTERED No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Hedwig Nelson

(a) RESIDENCE No. 2206 N. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

• (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	16	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER - George Nelson

11 BIRTHPLACE OF FATHER (city or town) Bergen
(State or country) Norway

12 MAIDEN NAME OF MOTHER - Caroline Andersen

13 BIRTHPLACE OF MOTHER (city or town) Christiania
(State or country) Norway

14 Informant George B. Nelson (Brother)
(Address) 2206 N. Charles St.

JUL 1 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 11, 1924, that I last saw her alive on July 11, 1924, and that death occurred, on the date stated above, at 10.35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) about yrs. 14 days mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam -

(Signed) T. F. Hall M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: July 14 1924

UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88579

CERTIFICATE OF DEATH.

D 88579
1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1611 Eutaw Place St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Caroline R Needham

(a) Residence No.....1611 Eutaw Place St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Asa Needham

6-DATE OF BIRTH (month, day and year): Aug 18-1842

7-AGE: 81 yrs. 10 mos. 23 ds. If LESS than 1 day ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Capt Francis Hollingshead

11-BIRTHPLACE OF FATHER (city or town) (State or Country): City

12-MAIDEN NAME OF MOTHER: Emily Pike

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): City

14-Informant: Asa Needham

(Address) 4232 22nd St

15 JUL 1 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from past 8 years 19.. to July 12 19 24

that I last saw her alive on July 11 19 24

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic congestion of Lungs

(Duration) ... yrs. ... mos. about 3 ds.

CONTRIBUTORY (Secondary): Senility

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? usual

(Signed) F. Labrie Ewalt M. D

7/13, 1924 (Address) 2945 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: July 14 19 24

20-UNDERTAKER: W. J. Gickner & Sons — ADDRESS: Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88580

CERTIFICATE OF DEATH.

91-002

D 88580

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3917 Park Heights Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Hertzberg

(a) Residence No. 3917 Park Heights Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6-DATE OF BIRTH (month, day and year) Dec. 28 1869

7-AGE. 54 yrs. 6 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Louis Hertzberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louise Hollander

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mr. Reipman

(Address) 3917 Park Heights Ave

15-FILED JUL 1 31924

ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/12/24

17- I HEREBY CERTIFY, That I attended deceased from July, 1924, to July 12, 1924, that I last saw h.e alive on July 12, 1924, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lutz, M. D.

7/12, 1924 (Address) 2040 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Bar Sinai Cem. DATE OF BURIAL, 7/14/1924

20-UNDERTAKER, David Sondheim ADDRESS 1122 W. Baltimore Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88581

CERTIFICATE OF DEATH.

29 D 88581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2-FULL NAME Mrs. Effie R. Day.

(a) RESIDENCE NO. 4105 Walnut Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Day.

6 DATE OF BIRTH (month, day, and year) June 24/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	44	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER Samuel Burdetta.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Miss Patrie Molesworth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Gomery Co. Md

14 Informant Husband.

(Address) 4105 Walnut ave

15 JUL 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17

I HEREBY CERTIFY, That I attended deceased from June 29/ 1924 to July 11 1924.

that I last saw her alive on July 11 1924,

and that death occurred, on the date stated above, at 3.35 p.m.

The CAUSE OF DEATH* was as follows:

Chr. cholecystitis, Cholelithiasis

Tetanus

(duration) yrs. 6 mos 3 ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of June 30/24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptomatology.

(Signed) [illegible] M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Montgomery Chapel, Montgomery Co.	July 13 1924
20 UNDERTAKER Harry H. Witzke	ADDRESS 1524 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

TYPE

S.A.E.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88582

CERTIFICATE OF DEATH.

162

D 88582
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S Patterson Park Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Ehlerich

(a) RESIDENCE NO. 216 S. Patterson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Morris Ehlrich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1437 E Baltimore St

Filed JUL 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1924, to July 12, 1924, that I last saw h.... alive on July 12, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Ulceration of Umbilicus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Septacemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Md. Gen. Hosp.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. B. Friedenwald, M. D.

, 19 (Address) 1616 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 7/13 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1409 E Baltimore St

BALK

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88583 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH Bay View Hospital 27 Registered No. D 88583

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donovan, Thomas E.

(a) Residence No. 212 Spalding Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Unknown

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do

12-MAIDEN NAME OF MOTHER, do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), do

14- (Informant) Bay View Hosp.

(Address) .....

15- JUL 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 11-1924

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to July 11, 1924, that I last saw h. ~~im~~ alive on July 11, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 7 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Paralysis.

? (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown,

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptomatic tests,

(Signed) [illegible] M. D.

7/12/ 1924 (Address) Wayburn Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, July 14 1924

20-UNDERTAKER, Page & Braun & Low — ADDRESS 118 West Royal Ave,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88584 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 88584

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Stiga

(a) Residence No. 831 W. Lombard st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Anthony Stiga

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER, Rosa Zokoskutia

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Lithuania

14- (Informant) Hospital Records

(Address) M.G.H.

15- Filed JUL 14 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1924 to July 12, 1924

that I last saw him alive on July 12, 1924

and that death occurred, on the date stated above, at 11.05 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema. Myocardial insufficiency with decompensation; chronic nephritis. (Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas. F. White M. D.

7-12-, 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	7/15 1924
20-UNDERTAKER.	ADDRESS
Chas. B. Kuckaustas	637 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88585 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88585

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1123 Sexton St., 21 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elenora M. Wyel

(a) Residence No. 1123 Sexton St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of August Wyel

6-DATE OF BIRTH (month, day and year) 12-19-1860

7-AGE. 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. AX Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bacto Md

PARENTS.

10-NAME OF FATHER, John C. Hoos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa Schulz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Herman Wyel

(Address) 1123 Sexton St

15- Filed JUL 14 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13 24

17- I HEREBY CERTIFY, That I attended deceased from July 9, 19 24 to July 13, 19 24

that I last saw h.. alive on July 12, 19 24

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Calcinoma

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Geo M Kieffer M. D.

July 13, 19 24 (Address) 2320 Druid Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	7/17, 1924
20-UNDERTAKER. Wm Cook	ADDRESS 502 E Nath

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-OD 88586

88586

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 9 WARD)

2-FULL NAME Victor Roskott

(a) RESIDENCE No 2030 Kennedy AVE. ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Five mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William Roskott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Freund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 9 - , 1924, to July 12 , 1924,
that I last saw h alive on July 12 , 1924,
and that death occurred, on the date stated above, at 1.40 P. m.
The CAUSE OF DEATH* was as follows:

Bacillary Dysentery
(Organism not identified)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) H. H. Wood, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 7/14 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Mon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88587 Med

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 6 WARD)

2-FULL NAME Marie Guttleman

(a) RESIDENCE No. 1725 E Jamison St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank Guttleman

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	62	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Boris Chernin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to July 13, 1924, that I last saw h alive on July 13, 1924 and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of thyroid
Generalized Carcinomatosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Alex Jacobson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrersburg	July 14, 24
20 UNDERTAKER	ADDRESS
Jack Davis 1439	Eldale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88588

CERTIFICATE OF DEATH.

185 D 88588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. JOseph gospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Baddock

(a) RESIDENCE No. 1714 Ruxton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ray Baddock

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing Mfg.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 045

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Baddock

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Bertha Rubin

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jack Lewis (Address)

15 Filed JUL 14 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured 5th cervical vertrabra
(Accidental-while diving at Bay Shore on June 21st)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Pullen (Coroner.), M. D.

7/13/24, 192 (Address) 508 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Friendship — DATE OF BURIAL July 14 192

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E. 30th

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88589

HEALTH DEPARTMENT—CITY OF BALTIMORE. D 88589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO. 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Diamond

(a) RESIDENCE No. 2029 McElderry St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxx

6 DATE OF BIRTH (month, day, and year) July 13/191[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	[illegible]			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Emanuel Diamond

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Rudetzky

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jack Lewis
(Address)

15 Filed JUL 14 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-struck by automobile
Fractured Skull
(Inquest July 14/24)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. K. Reis, M. D.
(Coroner.)

7/13/24, 192 (Address) 508nE. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int. Carmel | DATE OF BURIAL July 14 1924

20 UNDERTAKER Jack Lewis | ADDRESS 29 E Eads

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34D 88590

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Listes Hicks

(a) Residence No. 326 N. Schroeder St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1908

7-AGE, 16 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Charles Struttle

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Jennie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-

(Informant) Chas Struttle

(Address) 326 N Schroeder

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 8 1924 to July 11 1924

that I last saw him alive on July 11 1924

and that death occurred, on the date stated above, at 12-30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cervical Spinal Tuberculosis

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Faulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters

DATE OF BURIAL. July 14 1924

20-UNDERTAKER. John H. Toadvine

ADDRESS 142 W Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88591

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 88591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Wilson

(a) RESIDENCE. No. 910 Greenmellow ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Joynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Municipal Hospital Records

(Address)

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-3, 1924, to 7-11, 1924 that I last saw her alive on 7-10, 1924 and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude L. Dixon, M. D.

7-11, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 14 1924

20 UNDERTAKER ADDRESS 142

John H. Toadvine Uniontown

Spec.—1-10-21—M&T—1500 Blks.

D 88592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1929 D 88592

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6344 Montgomery ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Cornish

(a) RESIDENCE NO. 634 W. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Cornish

6 DATE OF BIRTH (month, day, and year) May 24 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) @ home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland.

PARENTS

10 NAME OF FATHER Thomas Parker

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Elsie White

(Address) 634 W. Montgomery

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 11 1924

17 I HEREBY CERTIFY, That I attended deceased from July - 4, 1924, to July, 11, 1924, that I last saw h[illegible] alive on July, 10, 1924 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine Findings

(Signed) Dan Brandenburg M. D.

7/12/1924 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 17 1924

20 UNDERTAKER John H. Toddbrin — ADDRESS 142 W. Lee St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88593

CERTIFICATE OF DEATH.

D 88593

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Washington Boulevard ST., 21 WARD)

2-FULL NAME Annie Bauman.

(a) RESIDENCE NO. 1214 Washington Boulevard. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73. yrs. mos. ds. How long in U. S., if of foreign birth? 73. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Bauman

6 DATE OF BIRTH (month, day, and year) June 26 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Edward Bauman

(Address) 1214 Washington Blvd.

JUL 14 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1924 to July 12 1924.

that I last saw her alive on July 11 1924.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) Edgar C. Traver M. D.

, 19 (Address) 1500 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 14 19 24
20 UNDERTAKER	ADDRESS
John J. Fillo	120 N. Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88594

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15-001

D 88594

REGISTERED NO.

CITY OF BALTIMORE: (No. 1327 W Lorey ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Ann Fish

(a) RESIDENCE. No. 1317 W Lorey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of James Russ Fish

6 DATE OF BIRTH (month, day, and year) Feb 17 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER John Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Eliza Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford

14 Informant James R. Fish (Address) 1317 W Lorey

15 Filed ..., 19 ... Registrar

JUL 14 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to July 11, 1924, that I last saw h alive on July 10, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible], M. D.

July 12, 1924 (Address) 1209 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 15 1924

20 UNDERTAKER Mrs James N. Dennis and T. C. Kelson

ADDRESS 1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88595

CERTIFICATE OF DEATH.

D 88595

REGISTERED No. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Presbman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sidney Savage

(a) RESIDENCE. No. 1323 Presbman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Savage

6 DATE OF BIRTH (month, day, and year): Unknown 1881

7 AGE — Years: 43 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Northumberland Co Va

PARENTS

10 NAME OF FATHER: Chris Bee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Corline Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Sadie Samuels
(Address) 1323 Presstman St

JUL 14 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to July 11, 1924, that I last saw her alive on July 10, 1924, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
(Cardiac Dilatation. Edema.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic symptoms

(Signed) Charles K. Hosier, M. D.

(Address) 712 S. Bond Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northumberland Co Va.	July 14 1924

20 UNDERTAKER: Mrs Jas H. Dennis per J. E. Kelson

ADDRESS 1303 Presstman St

Spec.—1-10-21—M&T—1500 Blks.

D 88596

HEALTH DEPARTMENT—CITY OF BALTIMORE

96-904 D 88596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. 72 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Siliuskas or Scelenske

(a) RESIDENCE No. 426 S. Para St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER John Sceleuske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1924

17

I HEREBY CERTIFY, That I attended deceased from June 28-, 1924, to July 12-, 1924.

that I last saw him alive on July 12-, 1924,

and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Renal tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1917

Was there an autopsy? no

What test confirmed diagnosis? Exam. urine

(Signed) R. V. McKay, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL July 15. 1924

20 UNDERTAKER John Grabianowski — ADDRESS 425 S Paca St

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88597 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 14 Ward) Registered No. 118

2-FULL NAME Harry McMaster

(a) Residence No. 2072 Linden Ave. St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary I Stauffer

6-DATE OF BIRTH (month, day and year) March 13/1884

7-AGE. 40 yrs. 3 mos. 29 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employed) Retail Grocery

(c) Name of employer A & P Tea Company

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John L. McMaster

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER, Susan C Barrett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frd Co Md

14- Mrs Harry McMaster (Informant)

(Address) 2072 Linden Ave.

15-

Filed JUL 14 1924 192 G.S. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12/24

17- I HEREBY CERTIFY, That I attended deceased from 7/11/24 19 to 7/12/24 19

that I last saw h. alive on 7/12/24 19

and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/11/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H O Harper M. D

19 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL,	DATE OF BURIAL,
Walkersville Frd Co Md	July 15, 1924
20-UNDERTAKER,	ADDRESS
Harry W. Eden	W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88598 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 D 88598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 Maryland Ave ST., Ra[illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie A. P. Kronenberg

(a) RESIDENCE No. 103 Maryland Ave. ST. Raspeburg WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. C. Kronenberg

6 DATE OF BIRTH (month, day, and year) Sept 29th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER John Strobel

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine McFadden

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant William Kronenberg (Address) 103 Maryland Ave. Raspeburg

15 Filed JUL 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1 , 1924 , to July 11 , 1924 .

that I last saw h[illegible] alive on July 10 , 1924

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests

(Signed) J M Bennett M. D.

19 24 (Address) 621 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 14 1924

20 UNDERTAKER: Frederick Lassahn & Sons — ADDRESS: Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Emerson Louis Sommerman)

D 88599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X118-09 88599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) University Hospital ST. WARD)

2-FULL NAME Emerson Louis Sommerman

(a) RESIDENCE NO. Rossville, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child. 6/20

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Emory F. Sommerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER Elsie Fitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Eloise Sommerman (Address) Fullerton Md.

15 Filed JUL 1 4 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/1924

17

I HEREBY CERTIFY, That I attended deceased from 7/5/24, 19 24, to 7/12, 19 24, that I last saw h[er] alive on 7/12/24, 19 24, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic ileus following intussusceptions & volvulus

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Paralytic ileus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 7/5/24. 7/12/24.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Luther C. Peterson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Perry Hall M.E. Cemetery — DATE OF BURIAL: July 15 1924

20 UNDERTAKER: Fredk. Lauchmer Sons — ADDRESS: Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement IS VERY important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88600 JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH.

D 88600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Feltenham

(a) RESIDENCE No. 209 N. Durham ST. St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of #

6 DATE OF BIRTH (month, day, and year) June 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work #

(b) General nature of industry, business, or establishment in which employed (or employer) #

(c) Name of employer #

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Caspe

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Kate Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) JOHNS HOPKINS HOSPITAL

14 Informant Records (Address) Girls Orphanage

15 Filed JUL 13 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1924

17

I HEREBY CERTIFY, That I attended deceased from July 9, 19 24, to July 13, 19 24, that I last saw h[illegible] alive on July 13, 19 24, and that death occurred, on the date stated above, at 8:10 a. m.

The CAUSE OF DEATH* was as follows:

General Miliary tuberculosis with tuberculous meningitis

(duration) mo. mos. 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) A. A. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL July 15 19 24

20 UNDERTAKER Stephen F. Walkowski ADDRESS 1100 S. Howard

Spec—12-23-21—E.B.R.S.—400 Bks.

(Nowicki)

D 88601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88601

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 514 S. Curley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nowicki

(a) Residence No. 514 S. Curley St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Joseph

6-DATE OF BIRTH (month, day and year) 1897 Sep 14

7-AGE, 26 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Ignacy Poniatowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Josephine Schmidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14-(Informant) Joseph L. Nowicki

(Address) 514 S. Curley

15-Filed JUL 14 1924 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12-1924

17- I HEREBY CERTIFY, That I attended deceased from June 28 1924 to July 12 1924 that I last saw her alive on July 11, 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease, following childbirth on June 28, 1924

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Hypostatic Congestion of the lungs (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronchar M. D

7-14 1924 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL, July 15 1924

20-UNDERTAKER, Stephen J. Trackowski — ADDRESS 100 S Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied **AGE** should be stated **EXACTLY**. Abbreviations should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

D 88602

1 PLACE OF DEATH

D 88602 -Baltimore City

Baltimore City

Ward or City (No. 4112 Lloyd Ave St.) (Ward) 28

If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 114

2 FULL NAME Margaret Kalb

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: Dec 9 (Month) (Day), 1842 (Year)

7 AGE: 81 yrs. 7 mos. 4 ds. If LESS than 1 day ..... hrs. or ..... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: ---Schneider

13 BIRTHPLACE OF MOTHER (State or country): Germany

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R Stevens

(Address) 4112 Lloyd Ave

Filed JUL 14 1924 192 Wm. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 13/24 (Day), 192 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 12 192, to July 13/24 192, that I last saw her alive on July 13/24 192, 4.50P and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Enteritis

7

(Duration) yrs. mos.

Contributory Secondary: Exhaustion

(Duration) yrs. 1 mos.

(Signed) Dr L Matthaei M.

7/14/24 192 (Address) CATONSVILLE, MD.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, ... yrs. .... mos. ....

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL: Salem Lutheran Cem — DATE OF BURIAL: 7/15 192

UNDERTAKER: Wm Cook — ADDRESS: 502 E Ma

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S No. 1.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88603

D 88603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Hampden Ave ST.: 12 WARD)

2-FULL NAME Edward P Duerring

(a) RESIDENCE. No. 634 Hampden Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna P Duerring

6 DATE OF BIRTH (month, day, and year) April 14 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. L Duerring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna P Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Mary Stonesifer

(Address) 634 Hampden Ave

15 Filed JUL 7 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to July 12, 1924 that I last saw h[illegible] alive on July 11, 1924 and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Cir Valv. heart (duration) Several mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Prof W D Hoff, M. D.

(Address) 1020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7/15 19 24
20 UNDERTAKER	ADDRESS
Franklin W Seitz	709 W 33rd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88604

D 88604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Francis Lysher.

(a) Residence No. 1725 Hanover St. St., 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 23, 1863.

7-AGE, 60 yrs. 8 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. B. & O. Engine-

(b) General nature of industry, business, or establishment in which employed (or employer). Inspector. 073

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. William E. Lysher.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Frances Dolphin.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Wife, Ida Olivia Lysher.

(Address) 1725 Hanover St.

15- Filed JUL 14 1924 192 Hano. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12/24

17- I HEREBY CERTIFY, That I attended deceased from July 1 1924 to July 12 1924

that I last saw h~~e~~ alive on July 12 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Independent

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

*What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

July 13/24 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery. July, 15, 1924.

DATE OF BURIAL,

20-UNDERTAKER. H. Howard Evans

ADDRESS 38 E. Fort Ave.

WHOLE EARNEST, WITHOUT ERASURE OR ALTERATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88605

D 88605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSP

CITY OF BALTIMORE: (No. Hall) ST., 28 (WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bowyn

(a) RESIDENCE NO. 4402 Pinkney ave. WARD 28

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? 59 yrs. 0 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 10, 1865

7 AGE: Years 59 Months 0 Days 2 If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conveyance

(b) General nature of industry, business, or establishment in which employed (or employer): x

(c) Name of employer: x

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Josie Bowyn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 14 1924 H. Ames Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8 , 1924, to July 12 1924 that last saw him alive on July 12, 1924, and that death occurred, on the date stated above, at 7.55 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas

Carcinomatosis of liver

(duration) 10 Days yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal hemorrhage

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jean Arnold, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: July 14 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS [redacted]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88606 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88606

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ashby

(a) RESIDENCE. NO. 211 Arch ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Ashby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records
(Address)

Filed JUL 14 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-9 1924, to 7-11 1924, that I last saw him alive on 7-10 1924, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis
Aortic Insufficiency
Myocardial Insufficiency (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Grace, M. D.

7-11. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J.W. Auburn Cem	July 14 24

20 UNDERTAKER R. C. Gross ADDRESS 1405 McElderry St

Spec.—1-10-21—M&T—1500 Bks.

17 3668

D 88607

D 88607 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88607

X118-002

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kaoka Fox

(a) RESIDENCE NO. Smithy. Will. Clearfield Ward

(Usual place of abode)

Length of residence in city or town where death occurred Pa yrs. mos. 13 ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of: George Fox

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 87 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Clearfield Co Pa

PARENTS

10 NAME OF FATHER: John Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): JOHNS HOPKINS HOSPITAL

Filed JUL 14 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to July 13, 1924 that I last saw her alive on July 13, 1924 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus post-operative.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Toxaemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July. 10, '24

Was there an autopsy? Yes

What test confirmed diagnosis? Culture

(Signed) Hen[redacted] Dinsd M. D.

, 19 (Address) The Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tyrone Pa — DATE OF BURIAL: July 14 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Ang

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88608 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88608

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 3718 Foster ave St., 26 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Schilpp.

(a) Residence No. 3718 Foster ave St., 26 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Schilpp.

6-DATE OF BIRTH (month, day and year) June 1—1879

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John G. Edelman

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Beh.

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country).

14-(Informant) William H. Schilpp.

(Address) 3718 Foster ave

JUL 14 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12-1924

17-I HEREBY CERTIFY, That I attended deceased from July 3 19 24 to July 12 19 24

that I last saw h alive on July 11 19 24

and that death occurred, on the date stated above, at 8.53A m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency

(Duration) 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hepatic Congestion Pulmonary Edema

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. D. Athey M. D

July 14 1924 (Address) 2504 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL, July 15th 1924

20-UNDERTAKER, Lilly & Zeller ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88609

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 N. Castle St ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ANNa Fischer

(a) RESIDENCE No. 1000 N. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Fischer

6 DATE OF BIRTH (month, day, and year) Nov 2/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	61	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Sooboda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Michawl Soul
(Address) 1000 N. Castle St

15 Filed JUL 14 1924 Hall Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis-(probably Valvular 8nsuff.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History Rheumatism 6 yrs ago (duration) yrs. mos. ds.

(Signed) J S Collins, M. D.
(Coroner.)

7/14/24, 192 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL 7/15 1924

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1734 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88610 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88610

CERTIFICATE OF DEATH. 118-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 S. Caroline St. Rd. Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gray

(a) Residence No. 16 S. Caroline St. Rd. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William Gray.

6-DATE OF BIRTH (month, day and year) Dec. 24-1852

7-AGE. 71 yrs. 6 mos. 18 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Ireland
(State or Country),

PARENTS.

10-NAME OF FATHER, John Dorn

11-BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country),

14- (Informant) Katherine E. Mills

(Address) 16 S. Caroline Road

15- JUL 14 1924 Filed..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 5 19 24 to July 12 19 24

that I last saw h.. alive on July 11 19 24

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ....yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? Physical findings

(Signed) James R. Dorsey M. D.

7/14, 1924 (Address) 1729 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet | DATE OF BURIAL, July 14, 1924

20-UNDERTAKER George L. Schwartz | ADDRESS 2nd. Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88611

D 88611

CERTIFICATE OF DEATH.

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. St. Agnes Hospital WARD)

2-FULL NAME Thos. W. Walston

(a) RESIDENCE NO. 3034 Stafford ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 8 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? —yrs. —mos. —ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29th 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Woodland G. Walston

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Grace M. McDonald

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant W. J. Walston
(Address) 3034 Stafford St

15 JUL 14 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (inquest, autopsy or inquiry) thereon and from the evidence obtained by ..... (inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body & arms burnt

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Companion threw a match in can of Gasoline

(duration) ..... yrs. ..... mos.

(Signed) ..... (Coroner.) ..... M. D.

July 12 1924 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL July 14 1924

UNDERTAKER P. O. Hilpert ADDRESS 1850 N Balto

MARGIN: AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 88612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 104 W Maple Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... George B. Weber (Overlea Md)

(a) Residence No. 104 W Maple Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Weber

6-DATE OF BIRTH (month, day and year) March 14/839

7-AGE, 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Ferdinand Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger

12-MAIDEN NAME OF MOTHER, Beyn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Henry A Jurgens

(Address) 104 W. Maple Ave

15- Filed JUL 14 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 24th 1924 to July 11th 1924

that I last saw h— alive on July 11th 1924

and that death occurred, on the date stated above, at 7.25 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile gangrene

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edward Benson M. D

, 19 (Address) Overlea Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, July 14 1924

20-UNDERTAKER, John Welsh — ADDRESS 608 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88613 ✓D 88613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1818 N Broadway ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis L Burlanger

(a) RESIDENCE NO. 1818 N Broadway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER John F Burranger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 NAME OF MOTHER Margaret Lee (Lee)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Lucille Burranger
(Address) 1818 N Broadway

15 Filed JUL 14 1924 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-1 1924 to 7-12 1924,
that I last saw him alive on 7-12 1924,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cardio Nephritis
Chr. Int. Neph.

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Myo carditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) L J Frame, M. D.
7-14 1924 (Address) 2953 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 15 July 1924

20 UNDERTAKER N Leakey & Son — ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88614

For ... 100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88614

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 N. Chester ST., 8 WARD)

2-FULL NAME Irvin C. Schario

(a) RESIDENCE NO 1408 N.Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Schario

6 DATE OF BIRTH (month, day, and year) May 2/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) formerly at
(c) Name of employer Sparrows Point

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Irvin Schario

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Catherine Schario
(Address) 1408 N. Chesapeake St.

Filed JUL 14 1924 H. A. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Collins, M. D.
(Coroner.)

7/14/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd	July 15 192 3
20 UNDERTAKER Elmer W. Conklin	ADDRESS 3144 Eastern

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88615 90 D 88615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Lizzie Johnson

(a) Residence No..... 1615 Penna Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 48 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cook

(b) General nature of industry, business, or establishment in which employed (or employer). ...

(c) Name of employer. ...

9-BIRTHPLACE (city or town) Cartersville (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, John Jefferson

11-BIRTHPLACE OF FATHER (city or town) Canton (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Julia Johnson.

13-BIRTHPLACE OF MOTHER (city or town) ... (State or Country), North Carolina

14- (Informant) ...
(Address) ...

15- JUL 14 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

1600

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/10/24

17- I HEREBY CERTIFY, That I attended deceased from July 9, 1924, to July 10, 1924, that I last saw her alive on July 10, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

General Cachexia

(Duration) ... yrs. ... mos. 21 ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL, JUL 14 1924, 19....

20-UNDERTAKER, | ADDRESS

UNIVERSITY OF MARYLAND

FILM

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓ D 88616

CERTIFICATE OF DEATH.

D 88616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 215 N. Montford ave. WARD 6)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Clark.

(a) RESIDENCE NO. 215 N. Montford ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-12-1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Clark.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Jessie Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Clark. (Address) 215 N. Montford Ave

15 Filed JUL 4 1924 19 ROBERT R. KRAUTER, Special Permit Clerk Registrar

4348

N. 217

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13-1924

17

I HEREBY CERTIFY, That I attended deceased from 7-12-, 1924, to 7-13-, 1924, that I last saw h alive on 7-12-, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

7 mos.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. B. Campbell, M. D.

7-13-1924 (Address) 614 N. Carolin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health.	ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Hutz~~ 3303 - Fleet St., No 26 Ward)

Registered No. 161-901

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Margaret Burger

(a) Residence No. 3303 Fleet St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, ~~Married,~~ ~~Widowed,~~ ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 13-1924

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 13 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Aaron Walter Burger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), York Pa

12-MAIDEN NAME OF MOTHER, Mary Madeline Wacker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Father

(Address) ~~Home~~ 3303 - Fleet

15- Filed JUL 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 14 1924

17- I HEREBY CERTIFY, That I attended deceased from 7/13/24, 19.. to 7/13, 19 24

that I last saw her alive on 7/13/24, 19..

and that death occurred, on the date stated above, at 4-30 a.m.

The CAUSE OF DEATH* was as follows:

Premature Labor

about six and one half months

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Premature Labor

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Wagenell M.D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart

DATE OF BURIAL. July 15, 1924

20-UNDERTAKER. Lilly & Zeiler

ADDRESS 403 S Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88618 ✓ D 88618

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N Bond St ST., 7 WARD)

2-FULL NAME Annie Winter

(a) RESIDENCE No. 512 N Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a [redacted] Widowed, of [redacted] HUSBAND of (or) WIFE of Henry Winter

6 DATE OF BIRTH (month, day, and year) Sept. 26 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Freitag

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdeline Speth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Trischman

(Address) 512 N Bond Street

JULY 4 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/24 19

17

I HEREBY CERTIFY, That I attended deceased from July 8 19 24 to July 12 19 24.

that I last saw h[redacted] alive on July 12 19 24,

and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A L Hornstein M. D.

19 (Address) 733 Ausquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 7/15/24

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88619

JOHNS HOPKINS HOSPITAL.

CERTIFICATE OF DEATH.

X 143 D 88619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Taylor.

(a) RESIDENCE NO. Towson, York Rd. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Stated.

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE — Years: 25 — Months: ? — Days: ? — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): +

(c) Name of employer: +

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Albert Steiche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records. (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 15 1924, 19 ... GS ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1924, to July 12, 1924, that I last saw h[illegible] alive on July 12, 1924, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Ruptured Tubal Pregnancy

Intra-Abdominal Hemorrhage

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary): none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ×

Did an operation precede death? yes Date of July 12-1924

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Georgett Gardner M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Rest Cem. DATE OF BURIAL: July 15 1924

20 UNDERTAKER: Frank D Kemsley ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks (Erline Ida Sellman)

655 W. Franklin
6264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88620

CERTIFICATE OF DEATH.

80 D 88620

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2633 W. Franklin St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Erline Ida Sellman

(a) Residence No. 2633 W. Franklin St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 28/1922

7-AGE, 1 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Jacob Sellman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER, Emma Brandt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) George Jacob Sellman

(Address) 2633 W. Franklin St.

15- Filed JUL 15 1924 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13th 1924

17. I HEREBY CERTIFY, That I attended deceased from July 11th, 1924, to July 13th, 1924, that I last saw her alive on July 13th, 1924 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions of
unknown origin
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Ochsman, M. D.

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Baltimore Cemetery	7/15/24
20-UNDERTAKER	**ADDRESS**
Geo. Pabst & Son	2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88621

CERTIFICATE OF DEATH.

D 88621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Ethel ST., 17 WARD)

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Gray

(a) RESIDENCE NO. 1123 Ethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Thos Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Thurston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Brooks

(Address) 1123 Ethel St

15 Filed JUL 15 1924, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to July 18, 1924, that I last saw her alive on July 13, 1924, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma cervix

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

July 13, 1924 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL July 16 24

20 UNDERTAKER Samuel D Wheatley — ADDRESS W Eddy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1249 88622

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., 19 WARD)

2-FULL NAME Frank Scott

(a) RESIDENCE No. 1613 W Lexington St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Scott

6 DATE OF BIRTH (month, day, and year) Nov 5 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab - Gen

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ed Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Nellie Scott

(Address) 1613 W Lexington St

15 Filed JUL 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to July 11, 1924,

that I last saw h in alive on July 11, 1924,

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. Manninger, M. D.

July 1/1924 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL July 15 1924

20 UNDERTAKER Emil B Hensley ADDRESS Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bruchey

(a) RESIDENCE. No. 1218 W. Pratt St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bruchey.

6 DATE OF BIRTH (month, day, and year) July 12th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Record (Address)

15 JUL 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-13, 1924, to 7-14, 1924

that I last saw him alive on 7-14, 1924

and that death occurred, on the date stated above, at 4 O a m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Epilepsy

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Kane, M. D.

7-14 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 16 1924

20 UNDERTAKER ADDRESS

John J. Fallon 120 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88624

CERTIFICATE OF DEATH.

5 3 | D 88624

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Vickers

(a) Residence No. 102 N. Front st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE	If LESS than 1 day
43 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS

10-NAME OF FATHER, Geo. Edw. Vickers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Digman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address) M. T. H.

15- JUL 15 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 26, 1924, to July 12, 1924, that I last saw him alive on July 12, 1924, and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Advanced pulmonary tuberculosis

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum, autopsy

(Signed) J. T. White, M. D.

7-14, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	July 15, 1924
20-UNDERTAKER	ADDRESS
Jas. C. Miller	2334 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88625

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 4206 Walnut Ave St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Perkins

(a) Residence No. 4206 Walnut Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Sophie Marshall

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER, Sarah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Mrs Sophie Marshall

(Address) 4206 Walnut Ave.

15- Filed JUL 15 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 9- 1924 to July 14- 1924

that I last saw h[illegible] alive on July 14- 1924

and that death occurred, on the date stated above, at 11-25 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

Intestinal obstruction

about
(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) strangulated hernia

about
(Duration) — yrs. — mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas L. McCarthy M. D

, 19 (Address) 2410 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. July 16 1924

20-UNDERTAKER. Wm Tuckner & Sons ADDRESS. Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Jane F Newman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88626

CERTIFICATE OF DEATH.

90 D 88626

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 649 W Franklin St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane F. Newman

(a) RESIDENCE NO 649 W Franklin St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Orleans
(State or country)

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Jane Symons

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Miss Jane E Newman
(Address) 649 W Franklin St

15 Filed ..., 192 ... Registrar

JUL 15 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) T K Jamison M. D.
(Coroner.)

July 15, 1924 (Address) 11 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 16 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88627

CERTIFICATE OF DEATH.

12 9D 88627

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Franklin Square ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth D. Nesses.

(a) RESIDENCE. No. 405 N Calhoun ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Finch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Elizabeth Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Amy Tipp

(Address) 170 Hollins St

15 Filed JUL 15 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1924, to July 14 1924, that I last saw h[e]r alive on July 13 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) Wade E. Kneupfer, M. D.

, 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 16 1924
20 UNDERTAKER George J. Smith	ADDRESS 153 Hollins

Spec.—1-10-21—M&T—1500 Bks.

D 88628 HEALTH DEPARTMENT—CITY OF BALTIMORE

117 D 88628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital. 21

CITY OF BALTIMORE: (No. Calhoun & Fayette ST., #35 WARD) 3

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel E. Sperlein

(a) RESIDENCE NO. 1126 Nanticoke ST., #35 WARD 111

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White (A)

5 (Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 8-1921

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin H. Sperlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Eva Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Martin H. Sperlein

(Address) 1127 Nanticoke St

JUL 15 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 10 1924, to July 12 1924, that I last saw h— alive on July 12 1924 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendix

(duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 12/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edw Emmel, M. D.

(Address) 817 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	July 1924
20 UNDERTAKER	ADDRESS
George J. Smith	532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

D 88629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88629

117

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., W WARD)

2-FULL NAME Mrs. Mary E. King

(a) RESIDENCE No. 412 South Chapel ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. King

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Frankard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt, Md

12 MAIDEN NAME OF MOTHER Sylvia Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John H. King (Address) 412 S. Chapel St

15 Filed JUL 1 5 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6 1924, to July 13 1924, that I last saw her alive on 7/13/24 1924, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of appendix, Pylorus, Liver, ovarian Cancers, 2 mos. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary), Post Operative shock and Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 7/11/24

Was there an autopsy? no

What test confirmed diagnosis? Oper. and Clinical

(Signed) W. [illegible], M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 16th 1924
20 UNDERTAKER Lilly & Zitzer	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88630 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 D 88630

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S Durham ST., 2 WARD)

2-FULL NAME Charlotte Kalinowski

(a) RESIDENCE NO 415 S Durham ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Other	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 2 ons

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Andrew Kalinowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Wentzlaman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Andrew Kalinowski
(Address) 415 S Durham

15 Filed JUL 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1924

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1924, to July 14, 1924.

that I last saw h... alive on ....., 19....;

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Signs & Symptoms

(Signed) Irby A Bullock, M. D.

7/14 1924 (Address) 162 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL July 15 1924

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

(Leverta Keyes)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88631

D 88631

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1134 Clarkson ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leverta Keyes

(a) RESIDENCE NO. 1134 Clarkson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Dec 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS

10 NAME OF FATHER Roy Keyes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Elnora Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Rocha Keller

(Address) 1134 Clarkson St

15 JUL 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to July 14, 1924, that I last saw her alive on July 14, 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? visual

(Signed) W. A. Smith, M. D.

July 14, 1924 (Address) 109 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Et — DATE OF BURIAL: July 16 1924

20 UNDERTAKER: A. W. Brown's Son — ADDRESS: 108 W. Mound

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 88632

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen Hosp ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Foner

(a) RESIDENCE NO. 11 E. 21st St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Weaver Foner

6 DATE OF BIRTH (month, day, and year) Nov 13, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carriage maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Foner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anne Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Wife Wm H. Foner 11-E-21st

15 Filed JUL 1 5 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 1, 19 24, to July 15, 19 24,

that I last saw him alive on July 15, 19 24,

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

Cystitis

Arteriosclerosis Chronic 11 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A. Dunkum M. D.

19 (Address) 1417 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 7/16 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88633

CERTIFICATE OF DEATH.

114 D 88633

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 17 WARD)

2-FULL NAME Thos. Wells Ports

(a) RESIDENCE No 2707 Barclay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara E. Ports

6 DATE OF BIRTH (month, day, and year) June 8/~~1862~~ 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Noah Ports

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Barbara E. Ports
(Address) 2707 Barclay St

15 Filed....., 192 ..... Registrar

JUL 15 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Gastro intestinal-

(Had eaten crabs etc)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Paca, M. D. (Coroner.)

7/15/24, 192 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grace Cem Carroll Co	July 16 1924
20 UNDERTAKER	ADDRESS
E LeRoy Stiffler	1755 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88634

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001 ✓

D 88634

Registered No.....

City of BALTIMORE: (No. 122 S. Exeter St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Neche Lemmer

(a) Residence No. 122 S. Exeter Street, Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry Lemmer

6-DATE OF BIRTH (month, day and year)

7-AGE. 46 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Jack Lewis

(Address) 1439 Eutaw St

15- Filed JUL 15 1924 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1924 to July 14 1924

that I last saw h.. alive on July 13 1924

and that death occurred, on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ....yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Cardiac Decompensation

(Duration) ....yrs. ½ mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A T Reis, M. D

July 15, 1924 (Address) 24 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL. July 14 1924

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88635

D 88635

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Bond St ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Blum berg

(a) RESIDENCE No 1117 N Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Blumberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Blumberg
(Address) 1117 N.Bond St

15 Filed JUL 1 5 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (Prob. Valv.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J S Mackenzie, M. D.
(Coroner.)

7/15/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Orphan Asy	July 15 1924
20 UNDERTAKER	ADDRESS
Isaac Levin	1439 E. Balto

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88636

CERTIFICATE OF DEATH.

D 88636

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 E.Biddle Street ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes E. Miller
2204 E.Biddle Street

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of XXXXXXXXX

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William M.Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Marysville Penna.

12 MAIDEN NAME OF MOTHER Selvia C.Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md.

14 Informant William M.Miller
(Address) 2204 E.Biddle Street

15 Filed JUL 1 5 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to July 15, 1924, that I last saw h[illegible] alive on July 15, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Epilepsy (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) W. E. Hertler M. D.

19 (Address) 1201 N Pat Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 7/18/1924

20 UNDERTAKER Albert L. Hiltz, Jr. — ADDRESS 1606 N.Chester St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1319 E. North Ave St., 9 Ward)

Registered No. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walker H. Patterson

(a) Residence No. 1319 E. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Nellie M. Patterson

6-DATE OF BIRTH (month, day and year) Nov 21-1892

7-AGE, 31 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Advertising Man

(b) General nature of industry, business, or establishment in which employed (or employer) Int. Harvester Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edwin Elmer S. Patterson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Elizar K. Walker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Nellie M. Patterson

(Address) 1319 E. North ave

13-

Filed 192

Registrar.

JUL 15 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 13-1924

17- I HEREBY CERTIFY, That I attended deceased from July 9 19 24 to July 13 19 24

that I last saw h[illegible] alive on July 13 19 24

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

acute Nephritis.

cup. Pleurisy Tub.

Hy Diabetes. Coma

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Hyde M. D

July 14 1924 (Address) 1100 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 7/16-1924

20-UNDERTAKER. Chas. H. Evans & Son

ADDRESS 118 W. Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Ismil

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88638

CERTIFICATE OF DEATH.

31 D 88638

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Tuberculosis Hospital, 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saleh Ismil

(a) Residence No. C/o British Consul St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1898

7-AGE.	If LESS than 1 day,
26 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Ocean steamer

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Arabia

PARENTS:

10-NAME OF FATHER, Saleh Ismil

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Arabia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Arabia

14- (Informant) Hospital Records

(Address) M.T.H.

Filed JULY 5 1924. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 14, 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 8 1924 to July 14 1924

that I last saw him alive on July 14 1924

and that death occurred, on the date stated above, at 12.25 p.m.

The CAUSE OF DEATH* was as follows:

Advanced pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pyopneumothorax, right side.

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. T. White, M. D.

7-14 . 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loraine Cem	July 15 24
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Bath St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gills

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88639

CERTIFICATE OF DEATH. X 155 D 88639

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Jack Gills

(a) RESIDENCE NO. Annapolis Junction ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Annapolis Junction
(State or country)

PARENTS

10 NAME OF FATHER James Gills

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mannebee

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant (Address) James Gills Annapolis Jct Md

Filed JUL 1 51924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to July 15, 1924, that I last saw him alive on July 15, 1924, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of left femur Bone with metastases to other parts of Body.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 6, 1924

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm Love Jr., M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	July 17 1924
20 UNDERTAKER Geo E French	ADDRESS Laurel Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88640

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1004 Bruntwood Ave (St.) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Clensen Blessing

(a) Residence No..... 1004 Bruntwood Ave (St.) ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 20-1920

7-AGE, 3 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm R. Blessing

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary E. Clensen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Wm R. Blessing

(Address) 1004 Bruntwood Ave

15- Filed JUL 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 30 1924 to July 14 1924

that I last saw h.. alive on July 13 1924

and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jno. C. Friedrich M. D.

7/14, 1924 (Address) 9362 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel July 16, 1924

20-UNDERTAKER, ADDRESS H. C. Friedfeld 914 Greenmt Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 88641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 88641

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen. Hosp ST. 24 (WARD)

2-FULL NAME Mr. Louis Kohlhoff Jr.

(a) RESIDENCE No. 1318 Webster ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Jessie Kohlhoff

6 DATE OF BIRTH (month, day, and year) May 18, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 129

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Kohlhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lois Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Louis J. Kohlhoff (Address) 1318 Webster st

15 Filed JUL 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to July 13, 1924, that I last saw him alive on July 13, 1924, and that death occurred, on the date stated above, at 2:00 P m.

The CAUSE OF DEATH* was as follows:

Tumor Brain
probably penile origin

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of { 6-9-24, 6-11-24, 6-21-24, 7-3-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) ..... M. D.

, 19 (Address) 1111 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 16 1924
20 UNDERTAKER E. Schlosman & Son	ADDRESS 1053 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88642

CERTIFICATE OF DEATH.

129

D 88642

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1732 Light St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Peters Jr.

(a) Residence No. 1732 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 14 1904

7-AGE: 20 yrs. 2 mos. 0 ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 840

(b) General nature of industry, business, or establishment in which employed (or employer): National Enam. Co.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Charles E. Peters Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Sophia Hammel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14-

(Informant) Charles E. Peters Sr.

(Address) 1732 Light St.

15-

JUL 1 5 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to July 14 1924

that I last saw him alive on July 14 1924

and that death occurred, on the date stated above, at 2 30 am.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

(Address) 16 E 4 Hamilton

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	7/16 19.24
20-UNDERTAKER	**ADDRESS**
J. Fenw. McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 88643

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 N Wolfe St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Shimanela

(a) Residence No. 911 N Wolfe St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Shimanela

6-DATE OF BIRTH (month, day and year)

7-AGE. 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Joseph Shimanela

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Mary Krauss

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14-

(Informant) Emma Shimanela

(Address) 911 N Wolfe St

Filed JUL 1 5 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13/24

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to July 13 19 24

that I last saw him alive on July 12 19 24

and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Uraemia & Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mr. Parrish mother Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Ryan M. D

July 14 1924 (Address) 801 21 Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	July 16 1924

20-UNDERTAKER. Frank Encker ADDRESS 1916 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 88644 — 74-001 — D 88644 Registered No.

City of BALTIMORE, (No. 2105 Barclay St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard A. Gleesner

(a) Residence No. 2105 Barclay St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Gleesner

6-DATE OF BIRTH (month, day and year): June 16 1854

7-AGE, 70 yrs. — mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): N.C.R.R.

(c) Name of employer: Retired 5 years

9-BIRTHPLACE (city or town) (State or Country): Pennsylvania

PARENTS.

10-NAME OF FATHER: Hamilton Gleesner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Mary A. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14-(Informant) Mrs. Mary A. Gleesner

(Address) 2105 Barclay St.

15-Filed JUL 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13-1924

17- I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to July 13, 1924, that I last saw h... alive on July 13, 1924, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy Atheroma Sclerosis.

(Duration) 5 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. Marsden, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cem. DATE OF BURIAL, July 16, 1924

20-UNDERTAKER, Horace H. Burgee ADDRESS 3623 Falls Road

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88645

CERTIFICATE OF DEATH.

100-601 D 88645

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McOwat

(a) RESIDENCE. No. Bay View Asylum St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland
(State or country)

PARENTS

10 NAME OF FATHER William McOwat

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 JUL 1 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-6, 1924, to 7-12, 1924, that I last saw him alive on 7-12, 1924 and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Emphysema
Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Brace, M. D.

7-12 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	July 16 1924

20 UNDERTAKER John D. Spence ADDRESS 2362 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88646

CERTIFICATE OF DEATH.

57 D 88646

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Asquith ST., 10 WARD)

2-FULL NAME Nicola Buccheri

(a) RESIDENCE No. 820 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Buccheri

6 DATE OF BIRTH (month, day, and year) 6/26-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gaetano Buccheri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosolia Di Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaetano Buccheri

(Address) 1924 Forrest St

JUL 5 1924 Filed 19

ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1924

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to July 13, 1924

that I last saw h[illegible] alive on July 13, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M. D.

July 15, 1924 (Address) 2407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 7/16 1924

20 UNDERTAKER George J. Kurtz

ADDRESS 1735 Harford Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 88647

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Annie Kuczynske

(a) Residence No. 2722 Dillon st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Felix Kuczynske

6-DATE OF BIRTH (month, day and year) 1896

7-AGE.	If LESS than 1 day.
28 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Alexander Gorzkoske

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER Mehalena Krgo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUL 16 1924 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 7 1924 to July 14, 1924 that I last saw h.. alive on July 14, 1924 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Advanced pulmonary tuberculosis.

Generalized amyloidosis.

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) J. J. White M. D.

7-14-, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Rosary	July 17, 1924
20-UNDERTAKER	ADDRESS
F. W. Ozaziewski	1900 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Piechoski)

D 88648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2046 Bank ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczyslaw Milton Piechocki

(a) RESIDENCE NO. 2046 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 28-22

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
2	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Michial Piechocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Budacz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Michial Piechocki 2046 Bank St

15 Filed JUL 16 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13 1924 to July 15 1924 that I last saw h— alive on July 14 1924 and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows: Cerebral meningitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic suppurative Otitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 16, 24
20 UNDERTAKER	ADDRESS
F. W. Ozazenski	1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen Hospital WARD 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Englehart

(a) RESIDENCE No. Laurel, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE OF Mrs. Chas Englehart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Maryland Gen. Hosp. (Address)

15 Filed JUL 16 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to July 15, 1924, that I last saw him alive on July 15, 1924, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Chr. interstitial nephritis

& uremia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Jno A Donaldson M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md — DATE OF BURIAL 7/16/1924

20 UNDERTAKER E A B Harle — ADDRESS 116 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 88650 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88650

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3246 E Baltimore St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Wolf

(Residence in Baltimore: No. 3246 E Baltimore St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: July (Month) 14 (Day) 1924 (Year)

7-AGE: .....yrs.....mos. 2/9 ds. If LESS than 1 day, 18 hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Salt Lake City

PARENTS.

10-NAME OF FATHER: Harry J. Wolf

11-BIRTHPLACE OF FATHER, (State or Country): Salt Lake City

12-MAIDEN NAME OF MOTHER: Meta M. Shenk

13-BIRTHPLACE OF MOTHER, (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry J. Wolf

(Address) 3246 E Baltimore St

15-

Filed JUL 16 1924

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foramen Imperforate

(Duration).....yrs.....mos. 3/9 ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) 0 yrs. 1 mos.....ds.

(Signed) James M Fenton M. D. (Coroner.)

July 15 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, 7/16, 1924

20-UNDERTAKER Philip Herring — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—i-10-21—M&T—1500 Bks.

D 88651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88651

CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Williams

(a) RESIDENCE NO. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

Filed JUL 16 1924, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1922, to 7-13, 1924 that I last saw her alive on 7-13, 1924, and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sob

(Signed) Claude A. Draper, M. D.

7-14, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 7/16/24, 19

20 UNDERTAKER Dennis Eaton ADDRESS 916 Pear

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88652 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88652

CERTIFICATE OF DEATH.

312

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 923 Ellen Place St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Roberts

(a) Residence No. 923 Ellen Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1901

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER, Ind Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER, Adelina Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Adelina Roberts

(Address) 923 Ellen Place

15- Filed ..... 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 7/13/24

17- I HEREBY CERTIFY, That I attended deceased from June 9 ....., 1924 ..to.. July 13 ....., 1924 that I last saw h.. alive on July 12 ....., 1924 and that death occurred, on the date stated above, at 7.65 p....m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis Consecutive

Pulmonary Tuberculosis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum test

(Signed) John C. Stevens M. D.

, 19 (Address) 73 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 7/16/24

20-UNDERTAKER: David Easton — ADDRESS 916 Mc

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-1921—M&T—1500 Bks.

1932 1

D 88653

HEALTH DEPARTMENT—CITY OF BALTIMORE

JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH.

31

D 88653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J Burton

(a) RESIDENCE NO. 514 Tranmere St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....—

(c) Name of employer .....—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Otto Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Florence Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 16 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1924, to July 15, 1924, that I last saw him alive on July 15, 1924, and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

1. Tuberculous Meningitis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Miliary Tuberculosis

(duration) yrs. mos. 15+ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Bagg, M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem | DATE OF BURIAL 7/16/24

20 UNDERTAKER Dan'l Corbin | ADDRESS 916 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 88654

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 N. Bruce ST., 19 WARD)

2-FULL NAME Louise Parker

(a) RESIDENCE NO. 6 N. Bruce ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Col.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-14-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (old)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Arthur Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mittie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant .....
(Address) .....

15 Filed JUL 16 1924, 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/24

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 14, 1924.

that I last saw her alive on July 14, 1924

and that death occurred, on the date stated above, at 2:10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Herman J. Dorf, M. D.

, 19 (Address) 3730 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7/16/24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88655

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Barrick St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Green

(a) RESIDENCE NO. 205 Barrick St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 10, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annearundel Co. Md.

12 MAIDEN NAME OF MOTHER Mitte Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mittie Green (Mother)

(Address) 205 N. Bruce St.

15 JUL 16 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 13th, 1924, to July 14th. 1924.

that I last saw him alive on July 14th. 1924.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 00 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Gaeting, M. D.

, 19 (Address) 16 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 7/16/24

20 UNDERTAKER Daniel Garber

ADDRESS 916 Penn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Swiencinska)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88656

CERTIFICATE OF DEATH.

31 D 88656

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 523 S Milton ave ST., 1 WARD)

2-FULL NAME Margyanna Swiencinska

(a) RESIDENCE NO. 523 S Milton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Jos~~ Oct. 14-1877

6 DATE OF BIRTH (month, day, and year) ~~Oct 10 1872~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~Oct~~	46 51	9 10	1 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Romatowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Rose Kleszczewski
(Address) 523 S Milton ave

15 Filed JUL 1 6 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/1/24 19... to 7/15/24 19..., that I last saw h[illegible] alive on 7/14/24 19..., and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

History (duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Feeney, M. D.

7/16/1924 (Address) 410 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 18 1924
20 UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88657

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Molly Fried.

(a) RESIDENCE NO. 1008 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham J. Fried

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Abes Finkelstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levy

(Address) 1439 Eutaw

15 Filed JUL 16 1924 H. Arms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to July 15, 1924, that I last saw h.. alive on July 15, 1924, and that death occurred, on the date stated above, at 7:20 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas with obstructive complications.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 13, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operative findings.

(Signed) J. Hoskovitz, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Forest &	July 18 1924
20 UNDERTAKER	ADDRESS
Jack Levis	1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88658

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Raspe ave ST. 26 WARD)

2-FULL NAME Mina Simmons

(a) RESIDENCE No. 21 Raspe ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Aaron Simmons

6 DATE OF BIRTH (month, day, and year): Mar 11 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	53	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Penna

PARENTS

10 NAME OF FATHER: Henry F. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lucinda Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Mrs. Schneider (Address) 21 Raspe ave Baltimore

15 Filed JUL 6 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1924 to July 14, 1924.

that I last saw her alive on July 14, 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A A Macdonald, M. D.

July 15, 1924 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

DATE OF BURIAL: July 1924

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112D 88659

Registered No.....

112D 88659

1-PLACE OF DEATH

City of BALTIMORE: (No. 1433 Covington St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Marie Smith

(a) Residence No. 1433 Covington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 30 1922

7-AGE. 2 yrs. 0 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Edward E. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Lillian Danielson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-

(Informant) Edward E. Smith

(Address) 1433 Covington St.

15-

Filed JUL 16 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 15 1924

17- I HEREBY CERTIFY, That I attended deceased from July 14 1924 to July 15 1924

that I last saw h alive on July 14 1924,

and that death occurred, on the date stated above, at 2 AM. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary) Acute Indigestion (with Convulsions)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McCullough, M. D.

7/15, 1924 (Address) 1074 William St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Pk Cem	7/17 1924
20-UNDERTAKER.	**ADDRESS**
J. Fen McCulley	130 E. Fort

IMPORTANT—ONE FORM ONLY FOR EACH DEATH. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88660

CERTIFICATE OF DEATH.

D 88660

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 690 Washington Blvd St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Chrestoplous

(a) Residence No. 690 Washington Blvd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2/20/1924

7-AGE. ..... yrs. 5 mos. ..... ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home girl

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Youngstown Ohio
(State or Country),

PARENTS.

10-NAME OF FATHER, John Chrestoplous

11-BIRTHPLACE OF FATHER (city or town)..... Greece
(State or Country),

12-MAIDEN NAME OF MOTHER Josephine Smitanosky

13-BIRTHPLACE OF MOTHER (city or town) Mt Pleasant Pa.
(State or Country),

14-

(Informant) John Chrestoplous

(Address) 960 Wash Blvd

15-

Filed..... 192.....

JUL 16 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 15 1924 to July 15 1924

that I last saw him alive on July 15 1924,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

.....(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

.....(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?* Clinical Findings

(Signed) John A. Buchman M. D

, 19 (Address) 650 Wash. Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents Cem

DATE OF BURIAL. 7.16., 1924

20-UNDERTAKER. George J Ruth

ADDRESS 1735 Hanford Av

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88661 — D 88661

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Curtis (Davis)

(a) RESIDENCE No. 1017 S. Howard St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital (Address)

15 Filed JUL 16 1924 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-8 1924, to 7-13 1924

that I last saw h[illegible] alive on 7-13 1924

and that death occurred, on the date stated above, at 7 P. M.

The *CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Thrombosis (Left Hemiplegia)

(duration) yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Bruce, M. D.

7-13 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Laurel Cemetery July 16 1924

20 UNDERTAKER — ADDRESS

Wm. R. A. Elliott 1175 Eastlund

Spec.—1-10-21—M&T 1500 Bks.

D 88662 Crystal

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/88662

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3 ST., WARD)

2-FULL NAME Mollie Crystal

(a) RESIDENCE NO. 1019 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prussia
(State or country)

PARENTS

10 NAME OF FATHER Samuel Morris

11 BIRTHPLACE OF FATHER (city or town) Prussia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Prussia
(State or country)

14 Informant Samuel Crystal
(Address) 1019 E Baltimore st

Filed JUL 16 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to July 16, 1924, that I last saw her alive on July 16, 1924, and that death occurred, on the date stated above at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 14, 1924

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Isidor J. Levy, M. D.

July 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 7/16 1924

20 UNDERTAKER Ad Stinson & Bro

ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88663 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88663

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Fawcett ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wylie

(a) RESIDENCE. No. 1138 Fawcett ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pond R. Road 073

(b) General nature of industry, business, or establishment in which employed (or employer) Employee

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas W. Wylie

11 BIRTHPLACE OF FATHER (city or town) Farmville (State or country) Prince Edward Co. Va.

12 MAIDEN NAME OF MOTHER Emily Hudson

13 BIRTHPLACE OF MOTHER (city or town) Farmville (State or country) Prince Edward Co. Va

14 Informant Mrs Ida Tucker (Address) 209 St. Benedict St

15 Filed ..... 19.. Registrar

JUL 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 1924, to ....., 1924, that I last saw h alive on July 14, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 17 1924
20 UNDERTAKER	ADDRESS 430 N. Eutaw
McGinnis & Carroll	Ridgewood Terr

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 88664 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 111-001 ✓ D 88664

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Birdie May Fowler

(Residence in Baltimore: No. 814 - E - 22nd St.; X yrs., 6 mos. X da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, JULY (Month) 7 (Day), 1885 (Year)

7-AGE. 39 yrs. XX mos. 9 da. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Westminster Md

PARENTS.

10-NAME OF FATHER, Geo W Cushing

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susie R Warner

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell C Fowler

(Address) 2615 Francis St

15-

Filed....., 191.....

JUL 16 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JUL 12 1924, to JUL 15 1924 191....., that I saw h..... alive on JUL 15 1924 191....., and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Shock

(Duration) X yrs. X mos. 1 da.

CONTRIBUTORY (Secondary) Gastric Ulcer

(Duration) X yrs. X mos. X da.

(Signed) O H Dukes M. D.

JUL 16 1924, 191.. (Address) 928 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Md St James Cemetery | DATE OF BURIAL. July 18 1924

20-UNDERTAKER C. M. Watts | ADDRESS Winfield, Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88665

CERTIFICATE OF DEATH.

D 88665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Van Denbergh

(a) RESIDENCE No. 3411 Springdale Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrol girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER F. A. VanDenbergh

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Zoda Arrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frederick A. VanDenbergh

(Address) 3411 Springdale Ave

15 JUL 16 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to July 15, 1924, that I last saw him alive on July 15, 1924, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Appendicitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 3411 Springdale Ave

Did an operation precede death? Yes Date of July 7, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Edward D. Johnson, M. D.

(Address) 1211 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	July 17 1924
20 UNDERTAKER	ADDRESS
H. W. Mears & Son	805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88666

CERTIFICATE OF DEATH.

118 D 88666

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard or Greene ST.) 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Warren Freburger

(a) RESIDENCE NO. 16 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Walter B. Freburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Gladys Chatman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) University Hosp. Records.

15 Filed JUL 16 1924 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13. 1924. to July 15. 1924.

that I last saw him alive on July 15. 1924.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 13

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) H. O. Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 16 1924

20 UNDERTAKER: Robert Burns & Son — ADDRESS: Calhoun & Hollins Balto Md.

Spec.—1-10-21—M&T—1500 Blks.

173 008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 88667

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D 88667

CITY OF BALTIMORE: (No.) ST. 12 WARD)

2-FULL NAME Walter Martin

(a) RESIDENCE NO. 2012 Hunter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9-1924

7 AGE: Years | Months | Days: 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Harvey Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Maggie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 JUL 16 1924 ROBERT R. KRAUTER, Registrar

1601 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 - 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1924, to July 4, 1924, that I last saw him alive on July 4 - 1924, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund B. Kuper M. D.

7/12. 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

D 88668 CERTIFICATE OF DEATH. D 88668

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Asylum St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John James A. Gannon

(a) Residence No. Bay View Asylum St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1842.

7-AGE. 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0440

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Washington Gardner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records.

(Address) Bay View Hospital

15- Filed JUL 18 1924 193 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

1608

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 13-24

17- I HEREBY CERTIFY, That I attended deceased from June 30, 1924 to July 13, 19 24 that I last saw him alive on July 13, 19 24, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene left foot

Indirect Inguinal Hernia (Right)

Senile gangrene (Duration) 20 yrs. 1 mos. ds.

Inguinal Hernia

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 5-1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab. Tests

(Signed) Ira P. Champe MD, M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 19....

20-UNDERTAKER. ADDRESS

Commissioner Health. JUL 16 1924

Per. Wm. E. WOODALL

UNIVERSITY OF MARYLAND

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 88669

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. D 88669 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Vogelsanecht

(a) Residence No. Newton St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Upholsterer

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do.

14- (Informant) Bay View Hosp.

(Address) .....

15- Filed JUL 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

29

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1924 to July 14, 1924

that I last saw h... alive on July 13, 1924

and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Psychosis with Senile Chronic Nephritis.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Edmunds Smith M. D.

7/16, 1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19..

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

JUL 16 1924

Rev. Wm. R. WOODALL

1607

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88670 CERTIFICATE OF DEATH. 162 D 88670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Carswell ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Larkins

(a) RESIDENCE. No. 1533 Carswell ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Albert Leroy Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Belz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert L. Larkins

(Address) 1533 Carswell Rd.

15 Filed JUL 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

1605

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-15, 1924, to 7-15, 1924

that I last saw him alive on 7-15, 1924

and that death occurred, on the date stated above, at 7 1/15 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? at birth died in 1 hr.

(Signed) Annie Fuller, M. D.

, 19 (Address) 1500 Edward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS JUL 16 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88671

CERTIFICATE OF DEATH.

31 D 88671

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Sharpless

(a) Residence No. 245 S. Schroeder st. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Sharpless

6-DATE OF BIRTH (month, day and year): 1895

7-AGE: 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Savannah Georgia

PARENTS:

10-NAME OF FATHER: John Howard

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Georgia

12-MAIDEN NAME OF MOTHER: Anna Gibbons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Georgia

14-

(Informant): Hospital Records

(Address): M.T.H.

JUL 16 1924

Burial Permit Clerk. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1924 to July 15, 1924

that I last saw her alive on July 15, 1924

and that death occurred, on the date stated above, at 9.25 a.m.

The CAUSE OF DEATH* was as follows:

Advanced pulmonary tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) J. D. Wiles, M. D.

7-15, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah, Ga. DATE OF BURIAL: July 16, 1924

20-UNDERTAKER: Jno. M. Johnson ADDRESS: 1309 Druid Hill Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17324³

D 88672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 13 ✓ D 88672

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME John C Magee

(a) RESIDENCE NO. 920 St. Paul Street ST., ... WARD Deland. Florida

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? 47 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jamie Lillian Magee

6 DATE OF BIRTH (month, day, and year): Aug 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Henry Magee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Eliz Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records JOHNS HOPKINS HOSPITAL.

(Address)

15 FILED JUL 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8 —, 1924, to July 11, 1924, that I last saw him alive on July 10, 1924, and that death occurred, on the date stated above, at 5-40 a m.

The CAUSE OF DEATH* was as follows:

Uremia Clinical Records.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock from injection

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? Yes Date of July 9-24

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Robert Wilkinson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: July 17 1924

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter on file 7-19-24 from Dr Lyle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88673

111-00

D 88673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Coughlin

(a) RESIDENCE NO. 11 Framon Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Margaret T. Cain

Feb 4 1885

6 DATE OF BIRTH (month, day, and year) 7/12/1874

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	45 39	+5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John J Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md. Ireland

12 MAIDEN NAME OF MOTHER Mary Connolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary C. Coughlin

(Address) #11 Framon Rd

15 Filed JUL 16 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16 1924

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 14, 1924, that I last saw him alive on July 14, 1924, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Peritonitis

Ruptured duodenal ulcer (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 10, 1924

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo B. Lyle M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/17/24

20 UNDERTAKER Geo J Ruth

ADDRESS 1735 Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 88674

CERTIFICATE OF DEATH.

5 129 D 88674

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 429 N. Gay St. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Guckenheimer

(a) Residence No. 429 N. Gay St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write which)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Guckenheimer

6-DATE OF BIRTH (month, day and year) May 29, 1838

7-AGE.	If LESS than 1 day
86 yrs. 1 mos. 25 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Leopold Louvenstein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Mr. Walter Leiby

(Address) 429 N. Gay St.

JUL 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/15/24

17- I HEREBY CERTIFY, That I attended deceased from January 1924 to July 15 1924

that I last saw h[illegible] alive on July 15 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis - nephritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leiby, M. D.

7/16, 1924 (Address) 2040 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Balto. Hebrew Cem.	7/17, 1924
20-UNDERTAKER.	ADDRESS.
David Londheim	18-20 W. Mt. Royal Ave.

WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88675

CERTIFICATE OF DEATH.

D 88675

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 436 W. Hamburg St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edna Markin

(a) Residence No. 436 W. Hamburg St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 9 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 30 1915

7-AGE. 8 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Girl

(b) General nature of industry, business, or establishment in which employed (or employer). W

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Michael Markin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Anna Levin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-(Informant). Michael Markin

(Address). 436 W. Hamburg St

15-FILED JUL 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/16/24

17- I HEREBY CERTIFY, That I attended deceased from June 19 24 to July 12th 19 24

that I last saw h.r alive on July 12 19 24

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

" " Stenosis

Cardiac Hypertrophy

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chr. parenchymatous nephritis (Duration) 2 yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Lab.

(Signed) D. A. Nicholson M. D.

7/16, 1924 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Hebrew Henry Run	7/16 19 24
20-UNDERTAKER,	ADDRESS
Sol Levinson + Bro	1127 E Balto St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88676

CERTIFICATE OF DEATH.

46D 88676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1352 Towson ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine C. Eder

(a) RESIDENCE NO. 1352 Towson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Francis J. Eder

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Joseph Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Mary Escherer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Mrs. Gustave Bohle (daughter)
(Address) 1352 Towson st

15 Filed JUL 16 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1923, to July 14, 1924, that I last saw h[illegible] alive on July 14, 1924, and that death occurred, on the date stated above, at 8:20 A. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uterine Cancer

(duration) yrs 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

July [illegible], 1924 (Address) 5 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 18 1924
20 UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D 88677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1460 D 88677.

1-PLACE OF DEATH So Balto Gen'l Hosp.

CITY OF BALTIMORE: (No. 1213 Light St. ST., 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ada V. Hubbard.

(a) RESIDENCE No. 926 Bevan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert J Hubbard

6 DATE OF BIRTH (month, day, and year) Jan. 31. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Laura Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Albert J Hubbard

(Address) 926 Bevan St.

15 FILED JUL 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924.

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to July 15, 1924

that I last saw her alive on July 15 1924

and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Pregnancy.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Puerperal Infection

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of June 28 1924

delivery

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) William B Dewitt, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 18 1924
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACCURACY should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88678 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88678

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 N. Henry ST., 19 WARD)

2-FULL NAME Charles Mrvichin

(a) RESIDENCE NO. 1316 N. Henry ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	D/C

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 22nd 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Alex. Mrvichin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Servia

12 MAIDEN NAME OF MOTHER Minda Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Servia

14 Informant Ved Mrvichin
(Address) 1316 N. Henry st

15 Filed JUL 16 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16/1924

17 I HEREBY CERTIFY, That I attended deceased from 7/14/24, 19..... to 7/16/24, 19 ,
that I last saw h— alive on 7/16/24, 19 ,
and that death occurred, on the date stated above, at 2.30 p.m.
The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) None yrs. mos 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Ed Terry, M. D.
7/17/24 (Address) 1316 N. Henry st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 17th 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88679

CERTIFICATE OF DEATH.

90 D 88679

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 6 WARD)

2-FULL NAME Miss Nannie Catlett

(a) RESIDENCE NO. Church Home Infirmary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None gfd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Port Royal Va
(State or country)

PARENTS

10 NAME OF FATHER Collin B Catlett

11 BIRTHPLACE OF FATHER (city or town) Port Royal Va
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Thornlay

13 BIRTHPLACE OF MOTHER (city or town) Port Royal Va
(State or country)

14 Informant Mrs. Celeste Sales.
(Address) Chancellor Va

15 Filed JUL 16 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1923, to July 16th, 1924.

that I last saw h.E.Y. alive on July 16th, 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Senility~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods.

(Signed) Gaylord Carothers M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredericksburg Va	4/17/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	1st & N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88680 HEALTH DEPARTMENT—CITY OF BALTIMORE 18-D 88680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2222 E Lombard St., 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Donald K. Towe

(Residence in Baltimore: No. 2222 E. Lombard St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: June (Month) 8 (Day) 924 (Year)

7-AGE: ....yrs. 1 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Salt Lk City.

PARENTS.

10-NAME OF FATHER: Donald Towe

11-BIRTHPLACE OF FATHER, (State or Country): North Dakota

12-MAIDEN NAME OF MOTHER: Olive Rockwood

13-BIRTHPLACE OF MOTHER, (State or Country): Bermuda Brit

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donald Towe

(Address) 2221 E Lombard

15- JUL 17 1924

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Instantaneous death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Gunshot Laceration Right Ventricle Heart

(Duration) ....yrs. ....mos. Sudden ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Hinton M. D.
(Coroner.)

(Address) 700 E Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Carmel. DATE OF BURIAL: July 17, 1924

20-UNDERTAKER: C. C. Reamer ADDRESS: 324 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88681

123 ✓ D 88681

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary St. 27 WARD)

2-FULL NAME Mrs. Laura Cooke.

(a) RESIDENCE No. Park Heights & Rogers Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles S. Cook

6 DATE OF BIRTH (month, day, and year): April 25 1862

7 AGE: Years 62 Months 2 Days 22 If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Zachary Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rose Earhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Charles S. Cook (Address): Park Heights & Rogers Ave.

15 Filed 7-17-24 GLG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1924.

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 16, 1924, that I last saw her alive on July 16, 1924 and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

[redacted]

Cholelithiasis.

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation. Cardiac

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of July 11, 1924.

Was there an autopsy? No Removal of gall stone

What test confirmed diagnosis?

(Signed) Keith C. Rice, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: July 19 1924

20 UNDERTAKER: Josiah Sypes — ADDRESS: 1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88682 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88682

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

City of BALTIMORE: (No. 2018 N Calvert St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanl Juanita Weber

(a) Residence No. 2018 N Calvert St., Ward,

(Usual place of abode)

Length of residence in city or town where death occurred 7 hrs old yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	—

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Wednesday July 16/1924

7-AGE. ....yrs....mos....ds. If LESS than 1 day, 7 hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, William Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Julia Viola Rogers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

11- (Informant) Lillian L. Lingan

(Address) 4719 Parkwood Ave

JULY 7 1924 H. A. W.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Wednesday July 16/1924

17- I HEREBY CERTIFY, That I attended deceased from birth July 16 19 24 to July 16 19 24

that I last saw h[illegible] alive on July 16 19 24

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

~~Duration~~ Exhaustion

(Duration) 7 hrs yrs. mos. ds.

CONTRIBUTORY ~~Duration~~ Exhaustion

(Secondary)

(Duration) 7 hrs yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Barrett C. Catlin M. D

, 19 (Address) 1404 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, July 17 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Fr Strong, 506 to Hopkins St
Cal. 3'11

D 88683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88683

100-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

Registered No.....

City of BALTIMORE: (No. ..... St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Rothrock

(a) Residence No. 1537 Cole St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 29, 1920

7-AGE. 3 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gone

(b) General nature of industry, business, or establishment in which employed (or employer) ppd

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS

10-NAME OF FATHER Robert Rothrock

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Anna Vaith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14-

(Informant) Robert Rothrock

(Address) 1537 Cole St

15-

Filed JUL 17 1924 H. Lane Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 14 1924 to July 15 1924

that I last saw him alive on July 15 1924

and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Primary - Broncho-Pneumonia

Immediate - Exhaustion

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death? 1537 Cole st.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J P Strong M. D

, 19 (Address) 506 Hanover st.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 18 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E. North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88684

CERTIFICATE OF DEATH.

14001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1906 E Eager St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Stumbaugh

(a) Residence No. 1906 E. Eager St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 8-1850

7-AGE, 73 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), East Berlin Adams Co Pa.

PARENTS.

10-NAME OF FATHER, Michael Stumbaugh

11-BIRTHPLACE OF FATHER (city or town) East Berlin (State or Country) Adams Co Pa.

12-MAIDEN NAME OF MOTHER, Lydia Hair

13-BIRTHPLACE OF MOTHER (city or town) E. Berlin (State or Country) Adams Co Pa.

14-

(Informant) Lydia Hair

(Address) 1906 E. Eager St.

Filed JUL 17 1924 19

Hair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year), July 16-24

17- I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19....., that I last saw h.....alive on....., 19....., and that death occurred, on the date stated above, at.....m. The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....(Duration).....yrs. 6 mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed).....M. D.

.....19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, East Berlin Adams Co. Pa.

DATE OF BURIAL, July 18, 1924

20-UNDERTAKER, Chas C. Miller

ADDRESS 2334 Jefferson St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88685

D 88685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 225 N. Wolfe St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isabelle Mrs. McCready

(a) Residence No. 225 N. Wolfe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm H McCready

6-DATE OF BIRTH (month, day and year) Jan 12-1860

7-AGE. 64 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Kifer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Martha Horsman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Wm H McCready

(Address) 225 N. Wolfe St

JUL 17 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 17 24

17- I HEREBY CERTIFY, That I attended deceased from Apr 14, 1924, to July 16, 1924,

that I last saw h. alive on July 16, 1924,

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. E. Keefer M. D.

July 17, 1924 (Address) 1301 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Co. DATE OF BURIAL, July 19, 1924

20-UNDERTAKER. Knox Co. ADDRESS Dukkes 2334 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88686

D 88686 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

REGISTERED NO. 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Rosenbaum

(a) RESIDENCE NO. 617 Cumberland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Rosenbaum

6 DATE OF BIRTH (month, day, and year) about 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Iesick Cohen

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Brona ----

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14
Informant J. Lewis
(Address) 1439 E. Balto. St.

Filed JUL 17 1924 A. Lane Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy ; M. D.
(Coroner.)

July 17, 1924 (Address) 2502 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Cemetery	July 17 1924
20 UNDERTAKER	ADDRESS
Jacob Lewis	1439 E. Balto

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D8868 7 HEALTH DEPARTMENT—CITY OF BALTIMORE D88687

CERTIFICATE OF DEATH. 122-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Gustave Ottenbacher

(a) RESIDENCE NO. 612 E Lombard WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Cook. 021

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Mattard Ottenbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Thermin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address) .....

15 Filed July 17-1924 [illegible] Registrar

1611

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/1924

17

I HEREBY CERTIFY, That I attended deceased from 7/13/24, 19..... to 7/17/24, 19.....,

that I last saw h~~e alive~~ on 7/17/24, 19.....

and that death occurred, on the date stated above, at 5.09 m.

The CAUSE OF DEATH* was as follows:

Metast Tuberculosis

Streptococcus Viridans ?

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holladay, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

UNIVERSITY OF MARYLAND

JUL 18 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-21

Spec.—1-10-21—M&T—1500 Blks.

D 88688

D 88688 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88688

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 551 Robert (St.) 14 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Hawkins

(a) RESIDENCE (No.) 551 Robert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lida Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Della Scott

(Address) 551 Robert St

15 Filed JUL 17 1924 H. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1924, to July 16, 1924, that I last saw h alive on July 15, 1924 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Jane E. Brown, M. D.

7/16, 1924 (Address) 1837 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-18 1924
20 UNDERTAKER	ADDRESS
George T. A. Gibson	1735 Division Hillman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 19-21-24—5,000 P.R.S.—400 Bks.

D 88689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88689

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Elizabeths' Home Chesnut Hill Que St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James King

(a) Residence No. St. Elizabeths' Home Chesnut Hill ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, negroe

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 31/23

7-AGE, ...yrs. 11 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md (State or Country),

PARENTS.

10-NAME OF FATHER, Arthur Wright.

11-BIRTHPLACE OF FATHER (city or town) Balto Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Dora King

13-BIRTHPLACE OF MOTHER (city or town) Kent Co. Md (State or Country),

14-

(Informant).....

(Address).....

Filed OCT 7 1924, 192.... Registrar.

1609

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 16/24

17- I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to July 15, 1924, that I last saw him alive on July 15, 1924, and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

July 16, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19..

20-UNDERTAKER,

ADDRESS

OCT 7 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22

Spec.—1-12-23—M&T—500 Bks.

D 88690

D 88690 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Columbia ave ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard J. Shanley

(a) RESIDENCE NO. 1232 Columbia Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. T. Shanley.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Kathrine Joyce

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14

Informant Mrs. Kathrine Shanley.
(Address) 1232 Columbia Ave.

15 Filed JUL 17 1924 W. A. Mc... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 16, 1924, that I last saw h[illegible] alive on July 16, 1924, and that death occurred, on the date stated above, at 9.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Brockman M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem. DATE OF BURIAL July 17 1924

20 UNDERTAKER Margaret E. Thyrum ADDRESS 1422 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88691

HEALTH DEPARTMENT—CITY OF BALTIMORE

100—D 88691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Cambridge ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Trocinik

(a) RESIDENCE NO. 2125 Cambridge ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10/24.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Trocinik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Paulina Patrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Trocinik

(Address) 2125 Cambridge St.

15 Filed JUL 17 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1924, to July 16, 1924, that I last saw her alive on July 16, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 17 1924
20 UNDERTAKER W. F. Sadowski.	ADDRESS 405 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

88692

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D 88692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis hospital 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Frank Geisler

(a) Residence No.... 5 W. West st. ....St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1863

7-AGE.	If LESS than 1 day,
61 yrs. ....mos. ....ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Andrew Geisler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant).... Hospital records

(Address)..... M.T.H.

15-

Filed JUL 17 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 21 1924 to July 15 1924,

that I last saw him alive on July 15, 1924,

and that death occurred, on the date stated above, at 10.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L. Sutton, M. D.

7-16-, 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cem A ac	July 17 1924

20-UNDERTAKER.	ADDRESS
James Dignan & Son	1000 S. Paca st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 88693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 88693

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 N. Chapel St. St., 6 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Lellen Drake Brashears

(a) Residence No. 116 N. Chapel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) May 2. 1924

7-AGE. Infant 14 days

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Brashears

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mame Kolbe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mame Brashears

(Address) 116 N. Chapel St.

15- Filed JUL 17 1924 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16, 1924

17. I HEREBY CERTIFY, That I attended deceased from June 21 1924, to July 16 1924,

that I last saw her alive on July 16 1924,

and that death occurred, on the date stated above, at 7 40 A.M.

The CAUSE OF DEATH* was as follows:

Colitis and Diarrhea

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) exhaustion

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death? 116 N. Chapel St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Watery, bloody, mucous stools

(Signed) W. N. Patterman M. D

July 17. 1924 (Address) 221 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pine Lawn — DATE OF BURIAL. July 19 1924

20-UNDERTAKER, Wendell & Upshur — ADDRESS 37 N. Chapel St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Beck)

D 88694

CERTIFICATE OF DEATH.

74-D 88694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Zeck

(a) RESIDENCE. No. 11 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a ~~If married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of John Zeck (Deceased)

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Shonate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Univergy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records (Address)

15 JUL 1 7 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-2, 1924, to 7-15, 1924

that I last saw her alive on 7-14, 1924

and that death occurred, on the date stated above, at 3-30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Thrombosis (Left Hemiplegia)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Grace, M. D.

7-15 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 15 1924

20 UNDERTAKER Wendell Duffel & Son ADDRESS 378 Am

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1926 D 88695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Declared dead at Johns Hopkins Hospital, 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Murray

(a) RESIDENCE NO Rear 1409 E. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): May 18/1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Vance Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Bessie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bessie Murray
(Address): 1409 E. Madison St

15 JUL 17 1924 GG Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/14/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Electrocution-fell against arc light wire while crossing street

Inquest to be held July 16/24 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S K Boiles, M. D. (Coroner.)

7/16/24 . 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury Cemetery — DATE OF BURIAL: July 18 192[illegible]

20 UNDERTAKER: Edward Bryan — ADDRESS: 163 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88696 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88696

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. William Degnan

(a) Residence No. Mt Hope Retreat St., 28th Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE~~ of Mrs Degnan

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
33 yrs. 0 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Auto Driver

(b) General nature of Industry, business, or establishment in which employed (or employer). Auto business

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Orange N J.

PARENTS.

10-NAME OF FATHER. Michael Degnan

11-BIRTHPLACE OF FATHER (city or town). (State or Country). New York

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). (?) Ireland

14- (Informant) Records Mt Hope (Address) Mt Hope Balto Md

15- FILED JUL 17 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 16-24

17. I HEREBY CERTIFY, That I attended deceased from July 12th, 1924, to July 16, 1924, that I last saw h. alive on July 16, and that death occurred, on the date stated above, at 6.15 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Hypostatic)

Post Acute Alcoholism

abt (Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

abt (Duration) 0 yrs. 0 mos. 21 ds.

18-Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Newark N. J.	Jul 17th 1924
20-UNDERTAKER	ADDRESS
J. G. Moran	3000 E. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88697 — D 88697

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 934 Little Cline St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Patrick H Mitchell

(Residence in Baltimore: No. 934 Little Cline St.; yrs. 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colord	Widower

6-DATE OF BIRTH. About ..... (Month) ..... (Day) 1881 (Year)

7-AGE. 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Drayton

(Address) 727 George St

15-

Filed ..... 192.. Registrar.

JUL 17 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 15 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Hennessy M. D. (Coroner.)

July 16 1924 (Address) 280 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	7/17-24
20-UNDERTAKER.	ADDRESS
Dan'l Easton	976 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓

D 88698

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence B. Gump

(a) RESIDENCE NO. Everett, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arline Gump

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer Southern Hardware Co

9 BIRTHPLACE (city or town) (State or country) Everett, Pa.

PARENTS

10 NAME OF FATHER H. Frank Gump Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ramsburg, Pa.

12 MAIDEN NAME OF MOTHER Barndollar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Everett, Pa.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 17 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7th, 1924, to July 17, 1924, that I last saw him alive on July 16th, 1924, and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Perineum

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Everett, Pa. DATE OF BURIAL 7/17/1924

20 UNDERTAKER E. J. Fanning & Son-1938 E. Lafayette ave. ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88699

CERTIFICATE OF DEATH.

74-001 V

D 88699

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 W. Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Rezek

(a) RESIDENCE. No. 1334 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vaclav Rezek

6 DATE OF BIRTH (month, day, and year) Jan 1, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Mozes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Prochaska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Vaclav Rezek
(Address) 1334 W. Lombard

15 Filed JUL 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to July 15, 1924, that I last saw h[illegible] alive on July 14, 1924, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchmass M. D.

, 19 (Address) 650 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	July 18 1924

20 UNDERTAKER Fred Frederick ADDRESS 1906 Bolton

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88700

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-0B 88700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Anthony ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Cope

(a) RESIDENCE NO. 1409 Anthony ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Charles A. Cope

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE About 62 Years — Months — Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mr. Klipper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Charles A. Cope

(Address) 1409 Anthony St

Filed JUL 17 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12th, 1924, to July 16th 24.

that I last saw her alive on July 16th 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Howard, M. D.

July 17, 1924 (Address) 501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL July 19 1924

20 UNDERTAKER Henry Kneck & Son — ADDRESS 1304 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88701 ✓ D 88701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital 17 54 Registered No.....

City of BALTIMORE: (No..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Albert Lehnert

(a) Residence No... 418 E. North Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) 1869.

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar store

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles G. Lehnert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Alberta Krapf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant), Mrs Charles E. Lehnert

(Address) 103 N. Virginia Ave

15- Filed JUL 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 9 1924 to July 16 1924

that I last saw him alive on July 16 1924

and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) See autopsy findings on back

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Hosp Hgs & Autopsy

(Signed) H. V. Harper M. D

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. July 18 1924

20-UNDERTAKER. Harry H Nitzke

ADDRESS 1531 N. Fulton Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 88702

CERTIFICATE OF DEATH.

101-001 D 88702

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 St Peter St ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Geissner

(a) RESIDENCE No. 758 St Peter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Kessner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bunchmayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. Keshner

(Address) 758 St Peter St

15 Filed JULY 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13th, 1924, to July 16th, 1924, that I last saw him alive on July 15th, 1924, and that death occurred, on the date stated above, at 12-25 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) E. L. Bampmee, M. D.

7-16-1924 (Address) 1929 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery, Baltimore Town — DATE OF BURIAL July 18 1924

20 UNDERTAKER Harry H. Nitzke — ADDRESS 1531 W Lombard St

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88703

CERTIFICATE OF DEATH.

5 D 88703

1-PLACE OF DEATH

City of BALTIMORE: (No. 4508 Loretta ave St., Hamilton Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Azalia M. Brezler.

(a) Residence No. 4508 Loretta ave St., Lauraville Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 2 1910

7-AGE. 14 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John J. Grant.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Alice C. Hurst.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balt.

14-

(Informant) John J. Grant.

(Address) 4508 Loretta ave Lauraville

15- Filed JUL 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 14 24

17- I HEREBY CERTIFY, That I attended deceased from July 7th 24 to July 14 19 24

that I last saw h. alive on July 14 19 24

and that death occurred, on the date stated above, at 2.55 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thos J Hurst M. D

19 (Address) 457 E Ostend.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. July 18 1924

20-UNDERTAKER. Geo. J. Reuter

ADDRESS 1735 Harford ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88704

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 D 88704

Registered No.

City of BALTIMORE: (No. 5101 Milford Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Mc Neil Sr.

(a) Residence No. 5101 Milford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Mc Neil

6-DATE OF BIRTH (month, day and year) July 31st, 1842

7-AGE: 81 yrs. 11 mos. 16 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Butcher

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

013

9-BIRTHPLACE (city or town) (State or Country): Ireland.

PARENTS.

10-NAME OF FATHER, Patrick McNeil

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary McCutcheon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Mrs Walter W. Correll

(Address) 5101 Milford Ave

15- JUL 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 17th, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to July 17, 1924.

That I last saw h~~im~~er alive on July 16, 19....,

and that death occurred, on the date stated above, at 12.30A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis.

(Duration) 3 or 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bowman Woodward, M. D.

July 17, 1924 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, July 19th, 1924

20-UNDERTAKER, J Sherman Gore — ADDRESS 1723 W Lafayette Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88705

CERTIFICATE OF DEATH.

162 D 88705

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

2-FULL NAME Baby Heyman

(a) RESIDENCE NO 1638 E. Balto. St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATIONS on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) July 13/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
			4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Morris Heyman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Etziekovitz

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Morris Heyman
(Address) 1638 E. Balto. St.

15 JUL 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Jaundice- Multiple abcesses over entire body-Abnormal at birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Culler, M. D.
(Coroner)

7/17/24, 192 (Address) 508 E. NorthAve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern cem. DATE OF BURIAL July 19 192 4

20 UNDERTAKER L. Levinson Bro ADDRESS 1158 Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-24 M&T 500 Bks.

D 88706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Sotirios Mamalis

(a) RESIDENCE NO. 1246 Beachwood ST., ... WARD St Barnus St. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Mamalis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Helen Pandelukas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Nicholas Mamalis

(Address) 1246 Beachwood Road

15 Filed JUL 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1924.

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 17, 1924, that I last saw him alive on July 17, 1924, and that death occurred, on the date stated above, at 2.50 A.m.

The CAUSE OF DEATH* was as follows:

general peritonitis

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of July 14, 1924.

Was there an autopsy? no

What test confirmed diagnosis? ....

(Signed) [illegible], M. D.

7/17, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 7/18 1924

UNDERTAKER Wm Fiaelson & Co

ADDRESS 1618 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88707

CERTIFICATE OF DEATH.

31

Registered No. D 88707

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Boone St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley R. Alexander

(a) Residence No. 2105 Boone St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Daisy Alexander

6-DATE OF BIRTH (month, day and year) Sept 24 1880

7-AGE. 43 yrs. 9 mos. 22 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 31

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: John J Alexander

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Belair Md

12-MAIDEN NAME OF MOTHER: Laura Harriman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Belair Md.

14-

(Informant): Miss Laura Alexander

(Address): 2105 Boone St

15-

Filed 1924 ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 16 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1924 to July 16 1924

that I last saw him alive on July 15 1924

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J C Rumbaugh M D

7-17-24 (Address) 1531 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park Cem. DATE OF BURIAL: July 18 1924

20-UNDERTAKER: Wm J Pickner Sons ADDRESS: Mottl & Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88708

CERTIFICATE OF DEATH.

38 D 88708

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp ST., 18 WARD)

2-FULL NAME Harry C. Schroeder

(a) RESIDENCE NO. 807 W Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 26th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 29

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Herr Schroeder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Lang

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Louise V. Schroeder
(Address) 234 E 22nd St

JUL 18 1924 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 — 17 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 17, 1924.

that I last saw him alive on July 17, 1924

and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebrospinal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Peters, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 19 1924
20 UNDERTAKER	ADDRESS
George Schillinger Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88709

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Abbottston St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ella Siebert

(a) Residence No. 1600 Abbottston St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ or (or) WIFE of Wm Siebert

6-DATE OF BIRTH (month, day and year) April 6-1870

7-AGE. 46 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 03

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore

(State or Country). Md.

PARENTS.

10-NAME OF FATHER. Louis Seine

11-BIRTHPLACE OF FATHER (city or town). Baltimore

(State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary L. Foltze

13-BIRTHPLACE OF MOTHER (city or town). Baltimore

(State or Country). Md

14-

(Informant). ~~Louis~~ Foltze

(Address) 1600 Abbottston St.

15-

Filed JUL 18 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 16/24

17- I HEREBY CERTIFY, That I attended deceased from June 15 1924 to July 16, 1924

that I last saw h alive on July 16, 1924,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Jos. R. L. Campbell M. D.

July 16, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dunkard Cemetery

DATE OF BURIAL, July 19 1924

20-UNDERTAKER. Chas C. Butler

ADDRESS 2334 Eastern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88710

CERTIFICATE OF DEATH.

139

D 88710

1-PLACE OF DEATH Church Home + Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Elizabeth Stuckert

(a) RESIDENCE NO. 1649 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer) Pitch Brook

(c) Name of employer Mr Pitch

9 BIRTHPLACE (city or town) (State or country) Baltimor Md

PARENTS

10 NAME OF FATHER Martin Stuckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katharine Mach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Katharine Stuckert (Address) 1647 E Eager St.

15 Filed JUL 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1924, to July 17, 1924, that I last saw her alive on July 17, 1924, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis —

Fibromyoma of Uterus —

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? — Mountain → 15 min

Did an operation precede death? Yes Date of July 5-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) A. M. Pelouze M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimor Cemetery — DATE OF BURIAL July 21 1924

20 UNDERTAKER Louis Heaman — ADDRESS 32 S Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88711

CERTIFICATE OF DEATH.

74 B 01 88711

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Seadenhall ST., 22nd WARD)

2-FULL NAME Carey Fisher

(a) RESIDENCE NO. 804 Seadenhall ST., 22nd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hester Fisher

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Steamboat Co.

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Wellen Fisher

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza Carey

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Edward Fisher

(Address) 1115 Park Ave

15 JUL 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16 1924

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to July 16, 1924, that I last saw h.m alive on July 15, 1924, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam., urine analysis

(Signed) William Roy Berry, M. D.

, 19 (Address) 1219 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 19 1924

20 UNDERTAKER John H. Joadin ADDRESS 142 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9 19—H. P. Co.—1000 Bks.

D 88712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 88712

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pearl

(a) RESIDENCE. No. 10 Painters Court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Joseph Pearl

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Municipal Hospital Records
(Address)

15 Filed JUL 18 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1924, to 7-15, 1924, that I last saw him alive on 7-15, 1924 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Drew, M. D.

7-15. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	July 19 1924

20 UNDERTAKER Thos J. & S. Locke ADDRESS 1302 Jeffery

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88713

CERTIFICATE OF DEATH.

31 D 88713

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E Rogers ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle Grosnell

(Residence in Baltimore: No. 104 E. Rogers ave St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan (Month) 19 (Day), 1840 (Year)

7-AGE, 84 yrs. 5 mos. 27 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Bennet Williams

11-BIRTHPLACE OF FATHER (State or Country), Fair Port Va.

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Fair Port Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm G. Towers

(Address) 104 E. Rogers ave

15- JUL 18 1924 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1924, to July 16 1924, that I saw her alive on July 15 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis,
Myocarditis + old age,
(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Heard to separate the causes
Ailing for many months,
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm F Watson M. D.

July 17, 1924 (Address) 2126 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md

DATE OF BURIAL, July 18, 1924

20-UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D88714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D88714

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2725 Hamsden ST.: 12 WARD)

2-FULL NAME William Thomas Smith Jr

(a) RESIDENCE. No. 2725 Hamsden ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Thos Smith Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Anne Merritt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Wm Thos Smith Sr 2725 Hamsden St

15 Filed JUL 18 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14th 1924, to July 17th 1924, that I last saw him alive on July 14th 1924, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Rupture
of Intestines
Tricuspid — (duration) 1 yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) 8 months pregnancy
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Wm Jameson M. D.

19 24 (Address) 1701 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	July 19 1924

20 UNDERTAKER CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88715

CERTIFICATE OF DEATH.

113 D 88715

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1349 Hull St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ellen Jackson

(a) Residence No. 1220 Hull St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 20 1924

7-AGE, yrs. 3 mos. 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Albert E. Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Carrie E. Berends

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Albert E. Jackson

(Address) 1220 Hull St

15- Filed JUL 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 17 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to July 17 1924

that I last saw h.. alive on July 17 1924

and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) A. L. Campbell M. D.

July 17, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel	July 18, 1924
20-UNDERTAKER. H. Sander Sons	ADDRESS 1710 Bank St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

123 ✓ D 88716

D 88716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hosp'l

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., ... WARD)

2-FULL NAME Philip Kirkwood.

(a) RESIDENCE NO. 140 South Ellwood Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Isabelle Kirkwood Ermina Collins Kirkwood

6 DATE OF BIRTH (month, day, and year) May 14, 1874.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
50 yrs.	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Sharp & Dohme

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Franklin Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ermina Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Deceased's wife (Address) 40 S. Ellwood Ave.

15 Filed JUL 18 1924, 19 GDS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16th 1924

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 16, 1924,

that I last saw h in alive on July 16, 19

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Choledocholithiasis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cholecystotomy & choledocholithotomy

b weeks later (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 14, 1924

Was there an autopsy? no

What test confirmed diagnosis? finding of stone

(Signed) Jay Martin, M. D.

, 19 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaee.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL July 19 1924

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 88717 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88717

CERTIFICATE OF DEATH.

REGISTERED NO. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 Rosebank Ave, St., 27 WARD)

2-FULL NAME Mary E Hunt.

(a) RESIDENCE No. 331 Rosebank ave, ST., Garrison WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of B. Franklin Hunt

6 DATE OF BIRTH (month, day, and year) apr 16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Joseph Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Louisa Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Daisy Hunt

(Address) 331 Rosebank ave

15 Filed JUL 18 1924 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to July 17, 1924, that I last saw h[illegible] alive on July 17, 1924 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? microscope

(Signed) Francis D McPherson, M. D.

, 19 (Address) 416 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govans, Presbyterian — DATE OF BURIAL July 19 1924

20 UNDERTAKER Wm. J. Tickner & Sons — ADDRESS North & Penna Ave City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3819 Belair Rd St., 26 Ward) Registered No. 47

2-FULL NAME.... Mary A. Rutledge

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3819 Belair Rd St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of John. Rutledge

6-DATE OF BIRTH (month, day and year) Aug 3 1866

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas H Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Elmmie B Moffitt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) John ~~Edward~~ Rutledge

(Address) 3819 Belair Rd

Filed JUL 18 1924 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 17-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923 to July 17, 1924

that I last saw h... alive on July 17, 1924

and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 7 1923

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Symptoms

(Signed) [signature] M. D.

7/17, 1924 (Address) Maple Ave Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: July 19, 1924

20-UNDERTAKER: Robt J Turner Sr — ADDRESS: 1442 N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88719

D 88719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2458 W. Baltimore St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elizabeth J. Robinson

(a) Residence No. 2458 W Baltimore St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Robinson

6-DATE OF BIRTH (month, day and year) Feb [illegible] 1852

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Rose Tomley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) David McGuire

(Address) 2458 W. Baltimore

15- Filed JUL 18 1924 19.. H. A. Mill Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16-1924

17- I HEREBY CERTIFY, That I attended deceased from November 24, 19.23, to July 16, 19.24, that I last saw h[illegible] alive on July 16, 19.24, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis

(Duration) 5 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis - Acute dilatation

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cooledge, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Old Cathedral Cemetery. DATE OF BURIAL, July 19 19.24

20-UNDERTAKER Robt J Turner & Son ADDRESS 1642 N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88720 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2129 N. Smallwood st. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Herman

(a) Residence No. 2129 N. Smallwood St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Herman

6-DATE OF BIRTH (month, day and year): Sept. 5, 1866

7-AGE: 57 yrs. 10 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

87

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Mr. Berger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Frederick Herman

(Address): 2129 N. Smallwood St.

15- JUL 18 1924 Filed, 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24, to July 17, 19 24

that I last saw her alive on July 17, 19 24

and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Rectum

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emily Wheeler, M. D.

7/17, 1924 (Address) 2129 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cem	July 19, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Bath St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88721

D 88721 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2705 Westwood Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lina Scott

(a) Residence No..... 2705 Westwood Ave. St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Howard K. Scott

6-DATE OF BIRTH (month, day and year) March 19, 1865

7-AGE	If LESS than 1 day,
59 yrs. 3 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ernest Starker

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christine Arneth

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Howard K. Scott

(Address) 2705 Westwood Ave.

15- JUL 18 1924 H. Adm Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 24, 19.., to July 16, 19..

that I last saw her alive on July 16, 19..,

and that death occurred, on the date stated above, at 11.15 Pm.

The CAUSE OF DEATH* was as follows:

Asthma - bronchial

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lung

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Ordinary

(Signed) H. Arnold, M. D.

7/17/24 (Address) 2202 W. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park Cem	July 19, 1924
20-UNDERTAKER,	ADDRESS
Rachel E. Cook	1002 W. Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88722

D 88722 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

36-004

1-PLACE OF DEATH

City of BALTIMORE: (No. 621 E 35th St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Edward Mc Sanders

(a) Residence No. 621 E. 35th St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 14-1907

7-AGE, 17 yrs. 5 mos. 3 ds. If LESS than 1 day ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Apprentice

(b) General nature of industry, business, or establishment in which employed (or employer) Paper Hanger

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo H. Sanders

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mamie A Geisel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Geo H. Sanders

(Address) 621 E 35th St

JUL 18 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 17/24

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1924 to July 17, 1924

that I last saw h.. alive on July 17, 1924

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

acute Nephritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. A. Dill, M. D.

(Address) 1733 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, July 19, 1924

20-UNDERTAKER, H. C. Wiedefeld | ADDRESS 1402 W. Lombard St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88723 ✓ D 88723

D 88723 HEALTH DEPARTMENT—CITY OF BALTIMORE 29

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 506 N. Luzerne Ave

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McNeill

(a) RESIDENCE NO. 506 N. Luzerne Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 77 yrs. 2 mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wm. McNeill

6 DATE OF BIRTH (month, day, and year) May 7 1847

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
77	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Langhorn Stark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Daughter 506 N. Luzerne ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13 1924 to July 7 1924 that I last saw h[er] alive on July 7 1924 and that death occurred, on the date stated above, at 7 25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Albuminuria

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertension arterio-sclerosis
Myocarditis Rheumatism 3 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Dobihal M. D.

19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL Jul 19 1924

20 UNDERTAKER John Ulrich

ADDRESS 2[nd] & Eden

Spec—12-23-21—E.B.R.S.—400 Bks.

Katzenberger, 1709 N Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88724

CERTIFICATE OF DEATH.

31 D 88724

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4000 Massachusetts Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Churchill Rhodes

(a) Residence No. 4000 Massachusetts Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 20. 1903

7-AGE, 20 yrs. 10 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): office

(c) Name of employer: Coppus Co.

9-BIRTHPLACE (city or town) (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Charles G. Rhodes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Emma Airey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): New Jersey.

14- (Informant) Emma Rhodes

(Address) 4000 Massachusetts Ave.

15- Filed JUL 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 17. 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 22 19 24 to July 17 19 24

that I last saw h. alive on July 16 19 24

and that death occurred, on the date stated above, at 8.20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) yrs. 2 mos. 24 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + Physical Ex

(Signed) [illegible] M. D.

7/18. 1924 (Address) 1729 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: July 19. 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 512 E Fayette Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88725 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88725

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 6 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Quaid

(a) RESIDENCE NO. 136 N. Potomac ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Quaid

6 DATE OF BIRTH (month, day, and year) July 7, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32	32	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife C 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER A. J. Hurley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore, Md.
12 MAIDEN NAME OF MOTHER Sarah Lindsimm
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Marie Quaid
(Address) 136 N. Potomac St

15 Filed JUL 18 1924 Hall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/24 19

17 I HEREBY CERTIFY, That I attended deceased from 7/13/24, 19..., to 7/17/24, 19...,
that I last saw her alive on 7/17/24, 19...,
and that death occurred, on the date stated above, at 4:30 p. m.
The CAUSE OF DEATH* was as follows:
Puerperal Sepsis

(duration) ... yrs. ... mos 5 ds.
CONTRIBUTORY (Secondary) Cardiac Failure + Toxemia (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical signs
(Signed) Jno A Tompkins, M. D.
, 19 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem Assn	July 18 1924
20 UNDERTAKER J J Moran	ADDRESS 300 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88726

D 88726 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88726

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Fraitare ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. McCormick

(a) RESIDENCE. No. 2423 Fraitare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ellen McCormick

6 DATE OF BIRTH (month, day, and year): Dec. 1864

7 AGE: Years 59 | Months 7 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): J. P. McCormick 2423 Fraitare

15 Filed JUL 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1924, to July 16, 1924, that I last saw h[illegible] alive on July 16, 1924, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis +
Chronic Nephritis unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Dilated heart
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. J. McEvoy M. D.

7/16, 1924 (Address) 834 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 7/19/24

20 UNDERTAKER: J. A. Moran ADDRESS: 3000 E Baltimore

...—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Langenberger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88727

CERTIFICATE OF DEATH.

90 D 88727

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Langenberger.

(a) RESIDENCE NO. Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. gd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St. Josephs Hosp. Records.
(Address)

15 Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to July 17, 1924,

that I last saw her alive on July 17th, 1924,

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Hypostatic congestion
Lungs.

(duration) yrs. 2 mos 17 ds.

CONTRIBUTORY (Secondary) Decompensation of Heart
Edema Lungs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam.

(Signed) J. S. Standing, M. D.

, 19 (Address) St. Jos. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: July 21 1924

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88728

CERTIFICATE OF DEATH.

D 88728

40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 N. Preston ST. | | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Connie Hatch

(a) RESIDENCE. NO. 148 N. Preston ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not definitely known, 1883

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 41 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Charles Holet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Maria Holet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: George Hatch
(Address): 609 Stump Alley

15 Filed ....., 19..... ROBERT R. KRAUTER, Registrar
JUL 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 19 24

17 I HEREBY CERTIFY That I attended deceased from July 12, 19 24, to July 16, 19 24, that I last saw h.. alive on July 16, 19 24, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pyelonitis
(Pyosalpinx - Gonorrhea)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

, 19 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park Cemetery Md — DATE OF BURIAL: July 20 19 24

20 UNDERTAKER: J. E. Brown Son — ADDRESS: 108 N. Mulberry

Robinson Sta a gcc 7/24

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88729

CERTIFICATE OF DEATH.

74-001 D 88729

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mount Hope Retreat St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Peter Sleckmyer

(a) Residence No. Mount Hope Retreat St., 26 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? over yrs. 35 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Sleckmyer

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE, About 68 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Restaurantier
(b) General nature of industry, business, or establishment in which employed (or employer): Saloon
(c) Name of employer:

9-BIRTHPLACE (city or town) (?)
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, Peter Sleckmyer

11-BIRTHPLACE OF FATHER (city or town) Alsace
(State or Country), France

12-MAIDEN NAME OF MOTHER, Catherine Finck

13-BIRTHPLACE OF MOTHER (city or town) Alsace
(State or Country), France

14-
(Informant) Records of Mt Hope Retreat
(Address) Mt Hope Retreat

15-
Filed....., 192.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 17th 1924

17. I HEREBY CERTIFY, That I attended deceased from June 29 1896 to July 17th 1924, that I last saw him alive on July 16th 1924, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy Sudden

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis (Duration) 26 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Hannery, M. D.

July 19, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, 7-19- 1924

20-UNDERTAKER, H. C. Brauning & Son — ADDRESS 516 N. Schroeder St

JUL 18 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88730

CERTIFICATE OF DEATH.

X 3/ D 88730

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 N. Eden St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Montegno

(Residence in Baltimore: No. 1216 N. Eden St.; ....yrs., ...mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
F	W	Married

6-DATE OF BIRTH. May (Month) 3 (Day), 1887 (Year)

7-AGE.	If LESS than 1 day,
36 yrs. ....mos. ....ds.	....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Louis Battaini

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gaetano Montegno

(Address) 1216 N. Eden St.

15- Filed JUL 18 1924 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1924, to July 17 1924, that I saw her alive on July 17 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Anemia

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Martin L. Tisdale M. D.

July 18, 1924 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Italy

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	July 19, 1924
20-UNDERTAKER Richard F. Curley	ADDRESS 1108 Guilford Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88731

CERTIFICATE OF DEATH.

X 40 D 88731

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hannah Mary Beard.

(a) RESIDENCE NO. 46 R 12 Delta, Penna. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Harry Beard.

6 DATE OF BIRTH (month, day, and year) Dec 23 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	30	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Peach bottom Twp. (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER John W Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Hospital Record.

(Address) — — —

15 Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 18, 1924, that I last saw her alive on July 18, 1924 and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

about 10 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Salpingitis unknown (duration) yrs. mos. duration ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of July 17, 1924

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) G. F. Goff, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Penna.

DATE OF BURIAL 7-19th 1924

20 UNDERTAKER C & B Hall

ADDRESS 115 E Main St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

38732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 38732

1-PLACE OF DEATH Church Home & Inf.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene L O'neill.

(a) RESIDENCE NO. Clayton N.C. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 23 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl-4-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Dixion O'neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Virginia Fennell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Alice O'neil
(Address) Clayton N. C.

15 Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/24/24, 19..., to 7/17/24, 19...
that I last saw her alive on 7/17/24, 19...
and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Esophagus

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Herbert Ancelet, M. D.

. 19 (Address) Clayton N.C.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clayton N C — DATE OF BURIAL 7/18/24

20 UNDERTAKER H E Hufham — ADDRESS 124 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 88733
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 116 S. Fulton ave. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian A. Deems

(a) Residence No. 116 S. Fulton ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female.

4-COLOR OR RACE: white

5-Single, Married, Widow, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. A. Deems

6-DATE OF BIRTH (month, day and year) 1874, July 4th

7-AGE. 51 yrs. 0 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md.

PARENTS.

10-NAME OF FATHER, John Henry Kahl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-
(Informant) Sister Comadeo
(Address) 116 S. Fulton ave

15-
Filed JUL 18 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 15 1924

17- I HEREBY CERTIFY, That I attended deceased from June 28, 1924 to July 15, 1924
that I last saw her alive on July 15, 1924
and that death occurred, on the date stated above, at 10 10 p. m.
The CAUSE OF DEATH* was as follows:

acute pulmonary tuberculosis

(Duration) — yrs. — mos. 18 ds. ?

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? I am not Know

Did an operation precede death? not Date of

Was there an autopsy? not Signs

What test confirmed diagnosis? None other than Physical

(Signed) George A. Kemp, M. D.

, 19 (Address) 1002 W Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, 7-19, 1924

20-UNDERTAKER, Robert Brooks & Son — ADDRESS S. E. Cor Calhoun & Hollins

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 88734

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Aliceanna ST., V WARD)

2-FULL NAME Boleslaw F. Grundwald

(a) RESIDENCE NO. 1717 Aliceanna ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10-1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Boleslaw Grunwald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Kath. Salajko

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Kath. Grunwald
(Address): 1717 Aliceanna

15 Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17 July 1924

17 I HEREBY CERTIFY, That I attended deceased from 13 July, 1924, to 17 July, 1924, that I last saw him alive on 17 July, 1924, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph L. Grunwald, M. D.

, 19 (Address) 601 S. Paca St, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: 7/19 1924

20 UNDERTAKER: Wm. Hagerty

ADDRESS: 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88735

CERTIFICATE OF DEATH.

21 ✓ D 88735

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Laurens ST., 16 WARD)

2-FULL NAME Miranda Briscoe

(a) RESIDENCE No. 1427 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Daniel Briscoe

6 DATE OF BIRTH (month, day, and year) Oct 28, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	39	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) H+

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) a. a. Co Md.

PARENTS

10 NAME OF FATHER ? Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) a a Co Md

12 MAIDEN NAME OF MOTHER Nat brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Daniel Briscoe

(Address) 1427 Laurens

Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to July 16, 1924.

that I last saw her alive on July 14, 1924.

and that death occurred, on the date stated above, at 7 ~~A~~ P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum Examination

(Signed) C. Wilbur Frey, M. D.

7/18, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL July 19 1924

20 UNDERTAKER Mrs James H. Dennis — ADDRESS 1303 Presstman St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 88736

D 88736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 E. 35th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Day

(a) RESIDENCE. No. 601 E. 35th ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Truman C Day

6 DATE OF BIRTH (month, day, and year) April 9- 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Adams Co Penna

PARENTS

10 NAME OF FATHER Wm W Witherow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Adams Co Penn

12 MAIDEN NAME OF MOTHER Mary R Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Truman C Day

(Address) 601 E-35th St

15 Filed JUL 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1924, to July 17, 1924, that I last saw her alive on July 17, 1924, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) C D Greenlee M. D.

1924 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Penna — DATE OF BURIAL 7/20 1924

20 UNDERTAKER William - Cook — ADDRESS 502 E Nan

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88737

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88737

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 922 Montpelier St. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kreiner.

(a) RESIDENCE. NO. 922 Montpelier ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) July 18, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank Anthony Kreiner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Helen Commiff.

13 BIRTHPLACE OF MOTHER (city or town) Towson
(State or country) Maryland.

14 Informant Frank A. Kreiner.
(Address) 922 Montpelier St.

15 Filed JUL 19 1924 Robert B. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 18, 1924, that I last saw him alive on July 18, 1924, and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Accident of Pregnancy.

Prematurity. 7 months.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) James Graham Marston, M. D.

7-18-1924 (Address) 814 Park Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7/19/1924
20 UNDERTAKER	ADDRESS
Engel & Tully	Fulton & Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 88738

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1046 N. Durham ST., 7 WARD)

2-FULL NAME Edward Wilson

(a) RESIDENCE NO. 1046 N. Durham ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Wilson

6 DATE OF BIRTH (month, day, and year): Jan. 1923

7 AGE — Years: — Months: 18 — Days: — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Ernest Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilson N. C.

12 MAIDEN NAME OF MOTHER: Bertha Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Selma

14 Informant: Ernest Wilson

(Address): 1076 N. Durham St.

15 Filed JUL 19 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1924 to July 17, 1924, that I last saw him alive on July 17, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. L. Robinson M. D.

19 (Address) 520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakley Cemetery — DATE OF BURIAL: July 19 1924

20 UNDERTAKER: Jos R A Elliott — ADDRESS: 725 Ashland Av

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3614 Railroad ave ST., 43 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Cresswell

(a) RESIDENCE NO. 3614 Railroad ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eulie Cresswell

6 DATE OF BIRTH (month, day, and year) Dec 5 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Cresswell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Wells

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John L. Cresswell
(Address) 3614 Railroad

15 Filed L 19 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage from Cancer of Stomach

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison, M. D.
(Coroner)

July, 1924 (Address) 1632 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel Howard DATE OF BURIAL July 20 1924

20 UNDERTAKER Ebenezer Deacon ADDRESS 36 Lafayette ave

CAUSE should be stated EXACTLY. PHYSICIAN'S should be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

D 88740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88740

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3222 Greenmount ave ST., 42 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. B. Onion

(a) RESIDENCE No 3222 Greenmount ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58.0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia R. Onion

6 DATE OF BIRTH (month, day, and year) Aug. 25-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Onion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine E. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John W. Onion

(Address) 1434 Homestead st

15 ROBERT F. HARRISON, ...19.....

Burial Permit Clerk. Registrar

JUL 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 15, 1924, that I last saw h. alive on July 15, 1924, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

of heart.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. J. Stricklen, M. D.

19 (Address) 632 Fawn ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	July 19 1924
UNDERTAKER	ADDRESS
Wm. E. Black	927 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1916 Mc Elderry St., 1 Ward) Registered No. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hettie Smith Packer

(a) Residence No. 1916 Mc Elderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John C Packer

6-DATE OF BIRTH (month, day and year) Nov 11 - 1871

7-AGE, 53 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John T Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Fannie Carney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Elizabeth Smith

(Address) 1916 Mc Elderry

15- Filed ..... 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16 - 1924

17. I HEREBY CERTIFY, That I attended deceased from April 24 19 24 to July 16 19 24

that I last saw h. 92 alive on July 16 19 24

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leoni M. D.

7/14, 1924 (Address) 430 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore County DATE OF BURIAL, July 21, 1924

20-UNDERTAKER. Thos E. Miller ADDRESS 2334 Boston

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88742

CERTIFICATE OF DEATH.

31 D 88742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 E. Church ST. 22 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Gross

(Residence in Baltimore: No. 29 E. Church St.; 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH, ... Sept. (Month) 15 (Day), 1848 (Year)

7-AGE,	If LESS than 1 day,
25 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Cyphas Gross

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elija J. Parker

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Cyphas Gross

(Address)..... 29 E. Church St.

15-

Filed..... 191.. Robert P. Harrison Registrar.

L 1 91924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1924, to July 17 1924, that I saw him alive on July 17 1924, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

..... Lobar Pneumonia

.....

.....

..... (Duration).....yrs.....mos...5....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)..... A. L. Shemwell M. D.

July 18, 1924, (Address) 2226 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn Ct	July 19, 1924

20-UNDERTAKER ..... ADDRESS

S. L. Brown & Son 1611 North Monty St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1730 88743 JOHNS HOPKINS HOSPITAL

D 88743

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Columbus Jones (Negro)

(a) RESIDENCE NO. 916 Watson St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1923

7 AGE: Years 1 Months 1 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER Annie Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 19 1924 A. D. 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 - 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to July 17, 1924, that I last saw him alive on July 17, 1924, and that death occurred, on the date stated above, at 4 45 a. m.

The CAUSE OF DEATH* was as follows: Tuberculous Meningitis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) General Miliary Tuberculosis

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 7/19/24

20 UNDERTAKER: R. C. Gross — ADDRESS: 1405 McElderry

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state if CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88744

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Presbury ST., 15 WARD)

2-FULL NAME Catherine Mabel Baker

(a) RESIDENCE NO. 1607 Presbury ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of James Baker

6 DATE OF BIRTH (month, day, and year) Nov 11 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dr Mayo County Md.

PARENTS

10 NAME OF FATHER Horace Crowdy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Mateus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Hawkens
(Address) 1607 Presbury St

15 L 19 1924 19 Robert P. Barrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1924, to July 16, 1924, that I last saw her alive on July 15, 1924, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. William Frey M. D.

7/16 1924 (Address) 1928 Fenwa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 20th 1924
20 UNDERTAKER	ADDRESS
A. Jones	111 S. Gilmor St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88745

D 88745

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Kellum

(a) RESIDENCE. No. 1308 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Kellum

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Md

PARENTS

10 NAME OF FATHER Charles Kellum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed . 19 Robert E. Harrison Registrar

JUL 9 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-8 . 1924, to 7-17 . 1924

that I last saw h~~im~~ alive on 7-17 . 1924

and that death occurred, on the date stated above, at 9.55 P.m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis

Aortic Insufficiency

Myocardial Insufficiency

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sob

(Signed) Claude A. Dixon, M. D.

7-17 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	July 19. 1924

20 UNDERTAKER Mrs R. A. Elliott ADDRESS 2425 Ashland Ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88746

CERTIFICATE OF DEATH.

188-002 D 88746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hosp ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hersh Cohen

(a) RESIDENCE No. 2427 McCulloh St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Cohen

6 DATE OF BIRTH (month, day, and year) about 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poltava Russia

PARENTS

10 NAME OF FATHER Morris Leib Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1434 E Baltimore St

15 Filed JUL 19 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Street car accident

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

July 19, 1924 (Address) 2802 East Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York	July 20 1924
20 UNDERTAKER Jack Lewis	ADDRESS 1434 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(Tuchman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88747

D 88747

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Appleton St. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Tuchman

(Residence in Baltimore: No. 1736 N. Appleton St. St.; 28 yrs., ... mos., ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15- JUL 19 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1923, to July 1924, that I saw h[illegible] alive on July 18 1924, and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation and insufficiency

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) Abraham Schapiro M. D.

July 18, 1924 (Address) 2029 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ahren Herring Lyn DATE OF BURIAL, July 20, 1924

20-UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88748

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5005 Beaufort Ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... David M. Neuberger

(a) Residence No. 5005 Beaufort Ave. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (write word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Jany. 26, 1909.

7-AGE. 15 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Student.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Falto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Moses Neuberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Rosa Stern

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-(Informant) Mr. Harry Cohen,
(Address) 5005 Beaufort Ave.

15-Filed ..... 192.....
Registrar.

JUL 19 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/17/24.

17- I HEREBY CERTIFY, That I attended deceased from July 15th 1924 to July 17th 1924

that I last saw him alive on July 16th 1924

and that death occurred, on the date stated above, at 11 A.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chorea

(Duration) ..... yrs. ..... mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Appendicitis

(Signed) A. Levingston M. D.

7/18/ 1924 (Address) 1017 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Friendship Cem.	7/20/....., 1924

20-UNDERTAKER.	ADDRESS.
David Sondheim	116-20 W. Mt. Royal Ave.

MARGIN RESERVED FOR BINDING

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: In case of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88749

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Katz

(a) RESIDENCE NO. Tampa Florida ST., WARD Tampa Fla.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Jew white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Adam Katz

6 DATE OF BIRTH (month, day, and year) May 24th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	52	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant 045

(b) General nature of Industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) Roumania (State or country)

PARENTS

10 NAME OF FATHER Isaac Katz

11 BIRTHPLACE OF FATHER (city or town) Roumania (State or country)

12 MAIDEN NAME OF MOTHER Yetta Arnstein

13 BIRTHPLACE OF MOTHER (city or town) Roumania (State or country)

14 Informant Mr. J. Gottesman (Address) New York

15 Filed ..... 19 ..... Registrar

JUL 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1924, to July 19, 1924, that I last saw him alive on July 19, 1924, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

? (duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Tampa Florida

Did an operation precede death? Yes Date of July 16, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Histological

(Signed) Jay Martin, M. D.

19 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn New York City

DATE OF BURIAL 7/20/1924

20 UNDERTAKER Harry Sondheim

ADDRESS 118-20 W. Mt. Royal

Spec—12-23-21—E.P.R.S.—400 Bks.

D 88750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88750

CERTIFICATE OF DEATH.

t 129

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lydia Morfoot

(a) Residence No. Annapolis Junction, Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Walter Morfoot.

6-DATE OF BIRTH (month, day and year)

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None 037

(b) General nature of Industry, business, or establishment in which employed (or employer). Housewife

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER. do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). do not know

12-MAIDEN NAME OF MOTHER. " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " " "

14- (Informant) Walter Morfoot

(Address) Annapolis Junction

15- Robert P. Harrison, Registrar.

JUL 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 18-1924

17- I HEREBY CERTIFY, That I attended deceased from July 12th, 1924, to July 18th, 1924, that I last saw her alive on July 18th, 1924, and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Acute Interstitial Nephritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Edgewater Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Savage Md. DATE OF BURIAL. 7-19-1924

20-UNDERTAKER. E & B Harle ADDRESS 115-21 E Main St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88751

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. Mary Kelley

(a) Residence No. 822 N. Fulton Ave. Baltimore Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J Kelley

6-DATE OF BIRTH (month, day and year)

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Do not know

(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

(c) Name of employer:.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town)..... " " "
(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town)..... " " "
(State or Country),

14-

(Informant) Thomas J. Kelley

(Address) 822 N. Fulton Ave

15-

Filed..... 192.. Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 18, 1924

17. I HEREBY CERTIFY, That I attended deceased from July 18th 1924 to July 18th 1924

That I last saw h.. alive on July 18th 1924

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus
Chronic Interstitial
Nephritis ?

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physicians Lab.

(Signed) H E Harker M. D

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL. 7/21 1924

20-UNDERTAKER, H. O. Means & Son — ADDRESS 805 N. Calvert st.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 8875'2

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88752

CERTIFICATE OF DEATH. 7159-002 D 88752

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bernard Wilson.

(a) RESIDENCE NO..... ST., ... WARD Bel Air, Md.-
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1927.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
0	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bel Air, Md.

PARENTS

10 NAME OF FATHER Josias Wilson

11 BIRTHPLACE OF FATHER (city or town) Man (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Josias Wilson Belair Md.

15 Filed JUL 20 1927 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1927, to July 19, 1927, that I last saw him alive on July 19, 1927, and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

(duration) 0 yrs. 0 mos 11 ds.

CONTRIBUTORY (Secondary) Congenital Heart Lesion.

(duration) 0 yrs. 0 mos. 26 ds.

18 Where was disease contracted if not at place of death? Bel Air. Md.

Did an operation precede death? yes Date of July 18, 1927.

Was there an autopsy? .....

What test confirmed diagnosis? Operation.

(Signed) Leroy Martin, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bel Air Md	July 20 1927
20 UNDERTAKER	ADDRESS
Jos T. Foster	Bel Air Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88753

CERTIFICATE OF DEATH.

118-002 D 88753

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 13 WARD)

2-FULL NAME Mr. Chas. E. Yager

(a) RESIDENCE No. 24-3 Francis St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Motorman

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER C C Yager

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sally Marshall

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed ..... 19 19 ROBERT R. KRAUTER Registrar

JUL 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/24

17 I HEREBY CERTIFY, That I attended deceased from 7/14/24 to 7/18/24,

that I last saw h~~—alive~~ on 7/18/24,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Perforation of intestines.

Intestinal Obstruction.

Peritonitis.

(duration) ~~yrs.~~ ~~mos.~~ 10 ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Necropsy

(Signed) H. W. Holley, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Va DATE OF BURIAL 7/20/24

20 UNDERTAKER Engelke Talley Sutton ADDRESS Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88754

CERTIFICATE OF DEATH.

12-8 D 88754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 844 Harford ave ~~Albert S. Shepard~~ ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert S Shepard

(a) RESIDENCE. No. 844 Harford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eliza Shepard
(Address) 844 Harford ave

15 JUL 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15 1924 to June 17 1924

that I last saw h... alive on June 17 1924

and that death occurred, on the date stated above, at 6-a m.

The CAUSE OF DEATH was as follows:

Cerebral Embolism

(duration) Sudden ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Kidneys & Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Richardson M. D.

(Address) 1122 N. 20th St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark Del. DATE OF BURIAL July 19 19..

20 UNDERTAKER Mac R. A. Elliott ADDRESS 1225 Ashland ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88755

CERTIFICATE OF DEATH.

D 88755

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. 9 ST., #36 WARD 3rd floor

REGISTERED NO. 4117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Dell osso

(a) RESIDENCE No. Franklin Sq Apts ST., WARD Newark N J

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred * yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
9	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna Pa

PARENTS

10 NAME OF FATHER Rocco Dellosso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER M Baddee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mendley Pacese

(Address) 2422 Barkley st

15 Filed JUL 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12th, 1924, to July 19, 1924, that I last saw her alive on July 19, 1924, and that death occurred, on the date stated above, at 5.15 P.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) Luigi D. DeStefano M. D.

1924 (Address) 1407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark N. J. DATE OF BURIAL July 21 1924

20 UNDERTAKER Robert Brokerson ADDRESS Cor Calhoun Collins Ave

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88756

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

v31 D 88756 Registered No.

City of BALTIMORE: (No. 1818 Bank St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merkel. Beckmann

(a) Residence No. 1818 Bank St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 20 1900

7-AGE.	If LESS than 1 day.
23 yrs. 6 mos. 29 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) New Orleans (State or Country) Louisiana

PARENTS.

10-NAME OF FATHER, Theodore Beckmann

11-BIRTHPLACE OF FATHER (city or town) New Orleans (State or Country) Louisiana

12-MAIDEN NAME OF MOTHER, Rosa . George

13-BIRTHPLACE OF MOTHER (city or town) New Orleans (State or Country) Louisiana

14- (Informant) Mr Theodore Beckmann

(Address) 1818 Bank Street

JUL 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 7 1924 to July 18 1924

that I last saw h.. alive on July 19 1924

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. 11 ds.

CONTRIBUTORY (Secondary) Asthenia & Dental fracture

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jno A Beckmann M. D

7/19 1924 (Address) 1623 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	July 22 1924
20-UNDERTAKER.	ADDRESS
John G. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A. DAK

Spec– 12-23-21–E.B.F.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88757

CERTIFICATE OF DEATH.

1 113 D 88757

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2108 Fleet St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anelia . Cialkowski

(a) Residence No. 2108 Fleet St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 28 1924

7-AGE. ....yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John. Cialkowski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Apolonia.Borkowski

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mr. John. Cialkowski

(Address) 2108 Fleet Street

15- JUL 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 19 1924

17- I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 19, 1924, that I last saw h. S. alive on July 19, 1924, and that death occurred, on the date stated above, at 10.00 m.

The CAUSE OF DEATH* was as follows:

Illio-coecitis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J. Rysanek M. D.

(Address) 501 N Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: July 21, 1924

20-UNDERTAKER: John H. Weber — ADDRESS: 1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88758

CERTIFICATE OF DEATH. 16-002 D 88758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1370 N Calhoun ST., 15 WARD)

2-FULL NAME Judson Adair

(a) RESIDENCE No. 1370 N. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lena Adair

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE — Years: 25 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevadore

(b) General nature of industry, business, or establishment in which employed (or employer): 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown 7-16-24

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lena Adair

(Address): 1370 N Calhoun St

15 Filed JUL 21 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 19 24

17 I HEREBY CERTIFY, That I attended deceased from 7-9-24, 19, to 7-16-, 19 24 that I last saw h. living on 7-15-24, 19, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Dysentery, Heat (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ve Date of

Was there an autopsy? ve

What test confirmed diagnosis?

(Signed) J. W. Adair M. D.

(Address) 1524 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: July 19 1924

20 UNDERTAKER: Emil T. Kemsley ADDRESS: 1524 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88759

CERTIFICATE OF DEATH.

117

D 88759

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 W. Mulberry St ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Virginia McGuire

(a) RESIDENCE NO. 1601 W.Mulberry St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Major McGuire

6 DATE OF BIRTH (month, day, and year): Aug. 8th. 1842

7 AGE: Years 41 Months 11 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Moses Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co. Va.

12 MAIDEN NAME OF MOTHER: Mary Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co. Va.

14 Informant (Address): Major McGuire (Husband) 1601 W.Mulberry St

15 Filed JUL 20 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/17/1924

17 I HEREBY CERTIFY, That I attended deceased from July 15th 24 to July 17th. 24

that I last saw her alive on July 17th/ 1924. 19

and that death occurred, on the date stated above, at 1;30 p.m.

The CAUSE OF DEATH was as follows*:

Acute Appendicitis

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: July 20 24

20 UNDERTAKER: Frank T. Kennedy & Bro. ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88760

CERTIFICATE OF DEATH.

74-001 D 88760

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #3803 Maine Ave. (Lauraville) ST., 47 WARD)

2-FULL NAME Katherine Hetchen

(a) RESIDENCE NO #3803 Maine Ave. ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 1st. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer Henry Meil

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Hetchen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Meil
(Address) #3803 Maine Ave.

15 Filed JUL 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th. 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Appoplexy

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) 1st stroke 14 yrs ago

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Hollis, M. D.
(Coroner.)

719/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 7/20 1924

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St.

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88762

CERTIFICATE OF DEATH.

123 D 88762

1-PLACE OF DEATH Union Memorial Hosp.

CITY OF BALTIMORE (No. ..... ST. 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley McPherson

(a) RESIDENCE NO. 315 Roland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State) Resident

Length of residence in city or town where death occurred 76 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? 76 yrs. 7 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Berry Barker McPherson

6 DATE OF BIRTH (month, day, and year) Nov 24 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer ..... None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John McPherson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Dogg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mr Barker McPherson (son) 11 E Baltimore St

15 Filed JUL 20 1924 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1924, to July 19, 1924, that I last saw him alive on July 19, 1924, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

Common Duct Stone

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 6/23/24

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) L. Martin, M. D.

19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 21st 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Supervisor) — ADDRESS [redacted]

Cor.—1-12-23—M&T—100 Bks.

D 88763

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

66 D 88763

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Jail. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rodgers.

(a) RESIDENCE No 2233 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced, WIFE (or HUSBAND) of Mary Rodgers.

6 DATE OF BIRTH (month, day, and year) May 30, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Rodgers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Martha Hayes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Barbara Tennyson. (sister)
(Address) 2233 E. Preston St.

15 Filed JUL 20 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

July, 18, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Do not know.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 21 1924
20 UNDERTAKER	ADDRESS
H. M. Routson	2205 N. Monta

21—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88764

D 88764

CERTIFICATE OF DEATH.

15 129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2906 W North St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tama F. Wall

(a) Residence No. 2906 W North St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry C Wall

6-DATE OF BIRTH (month, day and year) Aug 7 64

7-AGE.	If LESS than 1 day,
59 yrs. 11 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)... Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Wm E Compton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Lucie Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-
(Informant) Harry C Wall
(Address) 2906 W. North Ave

15-
JUL 20 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 18/24

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1924 to July 18, 1924 that I last saw her alive on July 18/24, 1924, and that death occurred, on the date stated above, at 12-10 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs....mos....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination and Eye Ground Examined

(Signed) Chas Leslie Timmerman, M. D.

, 19 (Address) 812 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	July 21, 1924
20-UNDERTAKER.	ADDRESS.
W M Routson	2238 N Monta

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 88765 — 129 D 88765

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Jefferson ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seymour Driggs.

(a) RESIDENCE NO. 1621 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Martha Driggs.

6 DATE OF BIRTH (month, day, and year) Dec 22 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Matthews Co. Va.

PARENTS

10 NAME OF FATHER Frank Driggs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Martha Driggs (Wife) 1621 Jefferson St

15 Filed JUL 20 1924 ROBERT R. KRANTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24. 1924. to July 17. 1924.

that I last saw him alive on July 17. 1924.

and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab.

(Signed) R. J. Upshur, M. D.

7/18 1924 (Address) 1426 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbury — DATE OF BURIAL July 20 1924

20 UNDERTAKER John W Henderson — ADDRESS 1002 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 88766

D 88766

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Meister Jr.

(a) RESIDENCE No. 2617 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B Meister

6 DATE OF BIRTH (month, day, and year) 1903 Feb 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21.	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto.

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic. 1876

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward J Meister Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Margaret B Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Record (Address)

15 Filed JUL 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/24

17 I HEREBY CERTIFY, That I attended deceased from 7/17/24, 19..., to 7/19/24 19, that I last saw h~~e~~ alive on 7/19/24, 19, and that death occurred, on the date stated above, at 9-a m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Sarcoma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laboratory

Did an operation precede death? No Date of 7/19/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 22 1924

20 UNDERTAKER W. J. Suchmer & Son — ADDRESS Walbrook

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 88767

CERTIFICATE OF DEATH.

D 88767 45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711- Ashburton ST., 15 WARD)

2-FULL NAME Mrs Mary A Rosenhans,

(a) RESIDENCE No. 1711 Ashburton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Fredk J Rosenhans

6 DATE OF BIRTH (month, day, and year) Jan 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
57	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Katelin Bogue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs F Rosenhans
(Address) 1711 Ashburton Ave

15 Filed JUL 20 1924 ROBERT F. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from about June 1st, 1924 to July 17th, 1924.
in last illness

that I last saw her alive on July 17th, 1924

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of rectum with secondary cancer of pylorus believed present.

(duration) not certain. yrs. ds.

~~CONTRIBUTORY~~ (Secondary) Probably 6 months.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Proctoscopy & exploratory O. H. Hoffman

(Signed) ..... M. D.

7/19, 1924 (Address) 3402 Wilbrook Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 21 1924
20 UNDERTAKER	ADDRESS
Wm Tucker & Son	North & Po

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88768

D 88763

1 PLACE OF DEATH University Hospital

REGISTERED NO. 146

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lanvale & Greene ST., 15 WARD)

2-FULL NAME Julia Robinson (Harris)

(a) RESIDENCE No. 1610 Laurens Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	black	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed - name unknown.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge, Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Lizzie Seabrease

(Address) 43[illegible] Fremont Ave

JUL 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16/24

17

I HEREBY CERTIFY, That I attended deceased from 7-10- 1924, to 7-16- 1924,

that I last saw her alive on 7-16 1924,

and that death occurred, on the date stated above, at 10 25 p. m.

The CAUSE OF DEATH* was as follows:

Puerperal infection.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-12-24

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) M. Alexander Morley, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/17/24
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88769

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3706 Fairfield Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Levy

(a) Residence No. 3706 Fairfield Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Levy

6-DATE OF BIRTH (month, day and year) 30 yrs

7-AGE [redacted] mos. ds.

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E. Baltimore St

15- Filed JUL 20 1924 ROBERT R. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20 1924

17- I HEREBY CERTIFY, That I attended deceased from July 12 1924 to July 20 1924

that I last saw her alive on July 12 1924

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulm T. B.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred L. Levy M. D.

7/20/24 (Address) 2005 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale — DATE OF BURIAL. July 20, 1924

20-UNDERTAKER. Jack Levis 1439 — ADDRESS E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-002

D 83770

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 W. Maple Av Cowba St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Herwig

(a) Residence No..... 14 W. Maple St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Herwig

6-DATE OF BIRTH (month, day and year) Sept 28. 1846

7-AGE. 75 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Retired Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 986
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS:
10-NAME OF FATHER, Christain Herwig
11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Gertrude Hildebrandt
13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-
(Informant)..... Lena Herwig
(Address)..... 14 W. Maple Cm

15-
Filed JUL 20 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 17 1924

17- I HEREBY CERTIFY, That I attended deceased from ...Jan 19 19.24.. to ...July 17 19.24
that I last saw h. alive on ...July 17 19.24
and that death occurred, on the date stated above, at 3 Pm.
The CAUSE OF DEATH* was as follows:

Cortens cirrosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) ... M. D.
, 19 (Address) Maple & Belair Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, July 20..., 1924

20-UNDERTAKER, John Herwig Jr — ADDRESS 2008 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 88771

D 88771

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 8 WARD)

2-FULL NAME Mrs Dora Maylan

(a) RESIDENCE No. 1619 Keyser ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh Maylan

6 DATE OF BIRTH (month, day, and year) April 15 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	47	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hugh Maylan

(Address) 1619 Keyser St

JUL 20 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 18, 1924, that I last saw her alive on July 18, 1924, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Serous Meningites. Chronic alcoholism. Subacute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo B. Sylvester, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	July 21 1924

20 UNDERTAKER — ADDRESS

George F. Ruth 1735 Hayford Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1D 4497 88772 JOHNS HOPKINS HOSPITAL. X 131 D 88772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abram Hess

(a) RESIDENCE No. 468 Banda Ave ST., ... WARD Johnson City Tenn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie C Hess

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tenn

PARENTS

10 NAME OF FATHER: Montgomery Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tenn

12 MAIDEN NAME OF MOTHER: Sarah Beckwith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tenn

14 Informant: Friends

(Address): JOHNS HOPKINS HOSPITAL

15 FILED JUL 21 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6 —, 1924, to July 20, 1924, that I last saw him alive on July 20 —, 1924, and that death occurred, on the date stated above, at 10:05 a. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6-6-24.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shorf, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnson City. Tenn.	July 21 1924

20 UNDERTAKER: Henry Lutz

ADDRESS 203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88773

CERTIFICATE OF DEATH.

3 D 88773

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 2023 Brunt St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Isaac James

(a) Residence No. 2023 Brunt St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Col | 5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary James

6-DATE OF BIRTH (month, day and year) 1888

7-AGE, 36 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (City or Town) (State or Country) Britch West Indies

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mary James

(Address) 2023 Brunt St

15- JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 19. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 8 1924 to July 19 1924,

that I last saw h... alive on July 19 1924

and that death occurred on the date stated above, at ....m.

The CAUSE OF DEATH was as follows:

Acute Phthisis

From History from Family

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Meningitis

(Duration) ....yrs. ....mos. 10 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Gabriel Chenault, M. D.

July 19, 1924 (Address) 1534 E. N. Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL, July 22nd 1924

20-UNDERTAKER, Joseph A Farrell | ADDRESS 2319 Dundalk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Fenton

D 88774

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 182 D 88774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fort & Luzerne ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L Morgan

(a) RESIDENCE No. Catonsville. Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 150
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Charles F Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Camden N J

12 MAIDEN NAME OF MOTHER Fannie Poyton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden N J

14 Informant C F Morgan
(Address) Bishop Road, Catonsville Md

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
fell from Launch at
wharf

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James W Faulon, M. D.
(Coroner.)

July 24, 1924 (Address) 10 E Clay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camden N. Jersey	July 21 1924
20 UNDERTAKER	ADDRESS
William Lake Sons	Catonsville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88775 CERTIFICATE OF DEATH. 101-001 D 88775

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital St.: 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rice

(a) RESIDENCE. NO. Bay View Asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ROBERT R. KRAUTER.
(Address) UNIVERSITY OF MARYLAND

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1924, to 7-15, 1924, that I last saw him alive on 7-15, 1924, and that death occurred, on the date stated above, at 12 20 P. M.

The CAUSE OF DEATH* was as follows:

~~Lobar Pneumonia~~
Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lob.

(Signed) Claude T. Vinson, M. D.

7-15 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	July 19 19 24

20 UNDERTAKER ADDRESS

Commissioner of Health.

Per. Wm. F. Wenck

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88776

CERTIFICATE OF DEATH.

D 88776

Registered No. 118001

1-PLACE OF DEATH
City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Sweetzone

(a) Residence No. 530 Orchard St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Indefinitely ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE.	If LESS than 1 day.
67 yrs. mos. ds.	hrs. or mln.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). South Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), South Carolina

14- (Informant) Hospital Records
(Address) Bay View Hospital

15- Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

1615

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 16 1924

17- I HEREBY CERTIFY, That I attended deceased from June 17th, 1924 to July 16, 1924
that I last saw him alive on July 16, 1924
and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Indirect Inguinal Hernia
Chronic Myocarditis
Senile Emphysema
(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Baltimore Md.
Did an operation precede death? Yes Date of 6-27-24
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab. Test
(Signed) H. R. Challpe. M.D. M. D.
(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
UNIVERSITY OF MARYLAND	July 19 1924

20-UNDERTAKER.	ADDRESS
Commissioner Health.	

For Wm. F. Peascott

SN. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 38777

1-PLACE OF DEATH

REGISTERED NO. D 38777

CITY OF BALTIMORE: (No. Belair Road opposite Kelly Ave. ST., WARD) Raspeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily P. Bell

(a) RESIDENCE NO. Belair Road opposite Kelly Ave. ST., WARD Raspeburg
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. K. Bell

6 DATE OF BIRTH (month, day, and year) July 4th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balty.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Bradley

11 BIRTHPLACE OF FATHER (city or town) Salisbury
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Mrs. Andrew Bell Daughter
(Address) Belair Rd. & Kelly Ave Raspeburg

15 Filed JUL 21 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1923 to July 18 1924

that I last saw her alive on July 17 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung
Probably Tuberculous.
myocarditis 6 mos ds.
(duration) yrs.

CONTRIBUTORY (Secondary) Odema of Lung 3 ds.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Webster, M. D.

, 19 (Address) 7131 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 21 1924
20 UNDERTAKER	ADDRESS
Fred'k Loose & Sons	Fulleton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88778

CERTIFICATE OF DEATH.

161-002

D 88778

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Hilliard ST., 19 WARD)

2-FULL NAME Catherine Krauss

(a) RESIDENCE No. 1804 Hilliard ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15 - 1924

7 AGE: Years . Months . Days 3 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Henry J. Krauss

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. C. Roelins

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Henry J. Krauss (Address) 1804 Hilliard St

15 Filed ... 19 ... ROBERT R. KRAUTER, Registrar

BURIAL PERMIT Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to July 19, 1924, that I last saw her alive on July 18, 1924, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) James H. Carmody M. D.

7/19, 1924 (Address) 1724 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 21 1924

20 UNDERTAKER: George L. Schwab — ADDRESS: 1711 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 88779

88779

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital W. Baltimore (Ward) 20

2-FULL NAME Mrs Stella Martin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 115 S. Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Martin

6-DATE OF BIRTH (month, day and year) June 5-1896

7-AGE. 25 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife Do not Use

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER George Wappenwitsch Do not Use

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), " " Md.

12-MAIDEN NAME OF MOTHER Annie Brun Jones

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) John Martin

(Address) 27 N. Bentalou St.

15- Filed JUL 21 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 19-24

17- I HEREBY CERTIFY, That I attended deceased from July 17 1924 to July 19 1924 that I last saw her alive on July 18 1924 and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H W Harper M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. July 22 1924

20-UNDERTAKER. George L. Schwab ADDRESS. 1501 Eutaw Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88780

CERTIFICATE OF DEATH.

X 129 D 88780

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U S Marine Hosp St., [illegible] WARD)

2-FULL NAME James Somers

(a) RESIDENCE NO. U S Marine Hosp ST., WARD Deals Island Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Somers

6 DATE OF BIRTH (month, day, and year) Mar. 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jackson Brodaham

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Somers

11 BIRTHPLACE OF FATHER (city or town) not known (State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country)

14 Informant U. S. Marine Hos. Records. (Address) 3 St. Remington Ave.

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18 1924 to July 20 1924 that I last saw h[illegible] alive on July 19 1924 and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Chronic Parenchymatous Nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical + Laboratory findings

(Signed) J. C. Travers, M. D.

3/20/24 (Address) U. S Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deals Island DATE OF BURIAL 7/22/24

20 UNDERTAKER H. E. Hughes ADDRESS 424 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

88781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88781.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 W. North Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Samuel Merritt

(a) RESIDENCE NO. 3402 W. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of Virginia Carr Merritt

6 DATE OF BIRTH (month, day, and year) July 20, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Tea

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Read

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Virginia C. Merritt

(Address) 3402 W. North Ave

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19. 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to July 19, 1924, that I last saw him alive on July 19, 1924, and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis -

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Austin T. Robinson M. D.

7-24 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 7-22-24 19

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 88782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 W. Henrietta ST., 22d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfences. Jones

(a) RESIDENCE No. 429 W. Henrietta ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John H Jones

(Address) 429 Henrietta St

15 JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/1924

17 I HEREBY CERTIFY, That I attended deceased from 7/15 1924 to 7/19 1924 that I last saw h[illegible] alive on 7/18 1924 and that death occurred, on the date stated above, at 7.00 P.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro. Enteritis

Abmet (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rachitis (Autopsy Sustained) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

7/21/1924 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel St — DATE OF BURIAL July 21 1924

20 UNDERTAKER A. E. Brown & Son — ADDRESS 108 W. Mt. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88783

CERTIFICATE OF DEATH.

90 D 88783

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Astor Court Apt ST., 17 WARD)

2-FULL NAME John. Reiser

(a) RESIDENCE NO. Astor Court Apt. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice W. Reiser

6 DATE OF BIRTH (month, day, and year) Dec 25 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58 Years.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Sales
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman.
(c) Name of employer

9 BIRTHPLACE (city or town) [redacted] (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Fred. Reiser

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany.

12 MAIDEN NAME OF MOTHER Magdaline Zentner

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Alice Reiser (Address) 2436 St Paul st

15 Filed ....., 192 ..... Registrar. ROBERT R. KRAUTER Burial Permit Clerk.

JUL 21 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aut- (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jabular Degeneration of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] Morrison, M. D. (Coroner.)

July 21, 1924 (Address) 3631 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL July 21 1924

20 UNDERTAKER John H. Whitehill — ADDRESS [illegible] W. Fayette

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88784

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Murphy

(a) Residence No. 2003 Lamley st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1903

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Factory work.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Thomas Day

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Helen Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 28, 1924 to July 18, 1924

that I last saw her alive on July 18, 1924

and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) J. F. White, M. D.

7-18, 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cemtry

DATE OF BURIAL. July 21, 1924

20-UNDERTAKER. Mrs Jas N. Dennis

ADDRESS 1303 Greastman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88785

CERTIFICATE OF DEATH.

D 88785

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 Pitcher St. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Johnson

(a) Residence No. 612 Pitcher St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Thelbert Johnson

6-DATE OF BIRTH (month, day and year): Mch 20-74

7-AGE: 50 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Co

PARENTS.

10-NAME OF FATHER: Wm Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Lenora Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-Informant: Thelbert Johnson

(Address): 612 Pitcher

15-Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 19-24

17- I HEREBY CERTIFY, That I attended deceased from May 9 - 1924 to July 19 - 1924 that I last saw her alive on July 18 - 1924 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Interstitial Nephritis

+ Dropsy (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) yrs. 4 mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. S. W. Kennard M. D

7-19-1924 (Address) 708 Cross av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Union Bethel Balto Co

DATE OF BURIAL: July 22 1924

20-UNDERTAKER: Sam'l R. Case & Son

ADDRESS: 1405 Mosher

Cor.—1-12-23—M&T—100 Bks.

D 88786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 D 88786

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Forrest St. ST., 5 WARD)

2-FULL NAME Patrick Price.

(a) RESIDENCE NO 524 Forrest St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Havre de Grace,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Tilghman Price.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Boyd.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Michael P. Boyd. 601 Otsego St.
(Address) Havre de Grace, Md.

15 JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)

July 20, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md.

DATE OF BURIAL 7-21 1924

20 UNDERTAKER Earle Hoar 115 E West St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88787

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D 88787

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Annie Connelly.....

(a) Residence No.....Preston Valley.....St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Connelly

6-DATE OF BIRTH (month, day and year)

7-AGE About 70 yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Edward Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Enright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant) Sister Florence

(Address) Preston Valley

Filed JUL 21 1924, 192... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 20/24

17- I HEREBY CERTIFY, That I attended deceased from None record, 19..., to ..., 19...,

that I last saw h.e.r alive on July 19, 19 24,

and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

3 Days (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July 23, 19 24 (Signed) F. H. Wards, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cem. | DATE OF BURIAL, July 23, 1924

20-UNDERTAKER, H. C. Windefeld | ADDRESS 914 Guilford Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88788

CERTIFICATE OF DEATH.

43 D 88788

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 St Paul ST., 17 WARD)

2-FULL NAME Edmund Amstead Boyd

(a) RESIDENCE No. 1610 St Paul St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia L. Boyd

6 DATE OF BIRTH (month, day, and year) July 13 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Employd

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Boyd

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Maryland

14 Informant Mrs Amelia L. Boyd
(Address) 1610 St Paul St

15 FILED JUL 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4. 1923, to April 25 1924, that I last saw him alive on April 25 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue & Tonsil

(duration) 1 yrs. 7 mos. ✓ ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Autopsy

(Signed) Sheldon Howell M. D.

7-24-, 1924 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 21 1924
20 UNDERTAKER	ADDRESS
John B Spence	1325 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imprtant. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88789

CERTIFICATE OF DEATH.

1924 D 88789

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital 24 ST., ... WARD)

2-FULL NAME Lawrence E. Skipper.

(a) RESIDENCE No 1709 Covington St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 10, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph E. Skipper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Gladys H. Lowery.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Lawrence A. Lowrey. (grandfather)
(Address) 208 E. Randall St.

15 Filed JUL 2 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage, rupture of the Liver and Kidney, injuries received while riding in an automobile recklessly driven into sightseeing bus.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Homicide

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

July 18, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Annapolis Blvd. nr. Cedar Hill Centry.

Former or usual residence July 17, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	7/21 1924

20 UNDERTAKER E. J. Fanning ADDRESS 1460 Battery

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88790

D 88790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1 159-003 Registered No. C.....

City of BALTIMORE: (No. 520 S Maynard St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jaby Stacharowski

(Residence in Baltimore: No. 520 S Maynard Av St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Sgl

6-DATE OF BIRTH, July 21 1924
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
..... yrs. ..... mos. ..... ds.	1 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, Adam Stacharowski

11-BIRTHPLACE OF FATHER, (State or Country) Balt City

12-MAIDEN NAME OF MOTHER, Veronica Drozd

13-BIRTHPLACE OF MOTHER, (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Stacharowski

(Address) 520 S Maynard Av

JUL 21 1924

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Teratoma Congenital

Hydro-Nephrosis from Ureters (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Congenital

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hanlon M. D.
(Coroner)

July 21 1924 (Address) 701 E Clay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Hamistans, Bm.	July 21 1924.

20-UNDERTAKER,	ADDRESS
M. J. Sadowski.	705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

KODAK

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88791

D 88791

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2423 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felicia Kropowicz

(a) RESIDENCE NO. 2423 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 5 1923

7 AGE: Years — Months: 8 — Days: 3. — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wladislaw Kropowicz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Szymanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Wladislaw Kropowicz 2423 Fleetwood St

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 20, 1924, that I last saw h. L. alive on July 20, 1924 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm T Reed, M. D.

July 21, 1924 (Address) 1211 Kennedy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem — DATE OF BURIAL: July 23 1924

20 UNDERTAKER: F W Ozazuski — ADDRESS: 1930 Eastend Ave

Spec.—1-10-21—M&T—1500 Bks.

D 88792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88792

CERTIFICATE OF DEATH.

113

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S. Collington Ave ST., 1 WARD)

2-FULL NAME Teodora Blusiewicz

(a) RESIDENCE No. 419 S. Collington ave ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov 7 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ballo Md

PARENTS

10 NAME OF FATHER: Alex Blusiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Sophie Drangel

13 BIRTHPLACE OF MOTHER (State or country): Poland

14 Informant: Alex Blusiewicz

(Address) 419 Collington

15 Filed JUL 21 1924, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17

I HEREBY CERTIFY, That I attended deceased from July 19 , 1924, to July 20 , 1924,

that I last saw him alive on July 19 , 1924,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Anne Arundel County

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) G F Rau, M. D.

July 21 1924 (Address): 24 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Jul 21 1924
20 UNDERTAKER	ADDRESS
J W Ozazewski	1932 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 1 7 3 88793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 179 D 88793

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Rosa A Gowers

(a) RESIDENCE NO. 1008 S 11 St Sparrows Point Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Harry Lowers

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H. Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elena Smyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records

JUL 21 1924

15 Filed ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7 — 1924, to July 17 — 1924, that I last saw her alive on July 17 — 1924, and that death occurred, on the date stated above, at 9 55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Harmon, M. D.

7/18, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL July 21 1924

UNDERTAKER Sam'l W. Case & Son

ADDRESS 1400 Madison

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88794

CERTIFICATE OF DEATH.

90 D 88794

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 Dartwood ast ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celia Moses

(a) RESIDENCE NO. 2842 Dartwood ast ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Moses

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jack Kranes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Crook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Eastern Ave

15 JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pulmonar Disease & Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Louis Morrison, M. D.
(Coroner.)
July 21, 1924 (Address) 2602 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Veteran Washington Rd DATE OF BURIAL July 21 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88795

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Bayview Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Alphonso Curry

(Residence in Baltimore: No. 912 N Cary St.; 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. July (Month) 26 (Day) 1903 (Year)

7-AGE. 20 yrs. 11 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Joseph Curry

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Henrietta Gordon

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alonzo Curry

(Address) 1315 Freeman St

15- Filed JUL 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: restraining
Strangulation by restraining sheet while he was in a mild delusional Accident)

(Duration) ..... yrs. Immediate ds.

CONTRIBUTORY (Secondary) Insanity yrs. 3 mos. ..... ds.

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) James M. Henderson M. D. (Coroner.)

July 21 1924 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 912 N Cary St

Former or usual residence 912 N Cary

19-PLACE OF BURIAL OR REMOVAL, Weston Star — DATE OF BURIAL, July 23, 1924

26-UNDERTAKER, John A Henderson — ADDRESS 1503 E Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

D 88796

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D 88796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 E. Oliver St ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Ellenberger

(a) RESIDENCE No 2129 E. Oliver St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Ellenberger

6 DATE OF BIRTH (month, day, and year) Oct 30/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gustus Ellenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Margraf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lena Ellenberger
(Address) 2129 E. Oliver St

15 Filed JUL 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Suicide (Possible Accident)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Culen, M. D.
(Coroner.)

7/21/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 23rd 192 4
20 UNDERTAKER C. Sattleman & Son	ADDRESS 1024 Hanover

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88797

REGISTERED NO. D 88797

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leeris S. Schloss

(a) RESIDENCE NO. 3205 Piedmont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 1668

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgetown D C.

PARENTS

10 NAME OF FATHER Seligman A Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Lagures

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Leeris Schloss

(Address) 3205 Piedmont Ave

15 JUL 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 20, 1924, that I last saw him alive on July 20, 1924, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) Chr. Diffuse Nephr. (duration) yrs. mos. ds.

Uremia

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 15 '24

Was there an autopsy? No.

What test confirmed diagnosis? Findings at Operation

(Signed) Jno A Tompkins, M. D.

, 19 (Address) M S Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 9/22/1924

20 UNDERTAKER David Londheim

ADDRESS 1128 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88798

CERTIFICATE OF DEATH

161-24

D 88798

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 White St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boby Kenney

(a) RESIDENCE. No. 1930 White St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/25/24

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Modesto
(State or country) Cal

PARENTS

10 NAME OF FATHER Wm Kenney

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Helen Dexter

13 BIRTHPLACE OF MOTHER (city or town) Wash
(State or country) D C

14

Informant

(Address)

JUN 27 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

1551

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/ 1924

17

I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h... alive on ....., 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Hollingsworth, M. D.

(Address) 912 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUN 26 1924 19
20 UNDERTAKER	ADDRESS
Commissioner Health,	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88799

CERTIFICATE OF DEATH.

57

D 88799

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Woodmand ST., 7 WARD)

2-FULL NAME Eliza M. Kremer (Kreamer)

(a) RESIDENCE NO. 819 Woodmand ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 04 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Kramer

6 DATE OF BIRTH (month, day, and year): Aug 6 1867

7 AGE — Years: 57 — Months: 0 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Traey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: George A. Kreamer (Address) 819 Woodmand Ave

15 Filed ..... 19 ..... Robert F. Harrison, Registrar
Burial Permit Clerk.

JUL 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 20th, 1924, that I last saw her alive on July 20th, 1924, and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Ed Hammond, M. D.

, 19 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Jul 23 1924

20 UNDERTAKER: Jos Jacobsen Son — ADDRESS: 2078 Pa

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 D 5585 — 122 D 88800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (over)

CITY OF BALTIMORE: (No. Kaczmorek ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kaczmorek

(a) RESIDENCE No. 22 N Curley St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 26 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER William Kaczmorek

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Frances Baltrukonis

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to July 21, 1924, that I last saw h alive on July 21, 1924, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/7/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bunn, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL July 23 1924

20 UNDERTAKER John H Weber — ADDRESS 1803 Bank St

MARGIN—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88801

CERTIFICATE OF DEATH.

143

D 88801

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 72 WARD)

2-FULL NAME Mildred Coulford

(a) RESIDENCE NO. 917 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tel. operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jos. F. Coulford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Catherine A. Brophy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Mollie Coulford (Address) 917 S. Charles St.

15 Filed JUL 21 1924, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1924

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 18, 1924, that I last saw h[illegible] alive on July 18, 1924, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured ectopic pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 917 S. Charles St

Did an operation precede death? Yes Date of July 18, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo B. Dyer, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL 7/22 1924

20 UNDERTAKER Fred A. Krause & Son.

ADDRESS 70 Hanover

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1924 473 B 88802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 B 88802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST. 21 WARD)

2-FULL NAME Ruth Hooper

(a) RESIDENCE No. 902 Bonjenly St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Clarence Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Esther Godfrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 JUL 21 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 20, 1924, that I last saw h[illegible] alive on July 20, 1924, and that death occurred, on the date stated above, at 6-10 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Unidentified)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kerper M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	July 22 19 24
20 UNDERTAKER Wash B Cook	ADDRESS 602 N. Balto

FORM 902 20M 8-20

THE JOHNS HOPKINS HOSPITAL

WINFORD H. SMITH, M. O., DIRECTOR

WARFIELD T. LONGCOPE, M. D.
PHYSICIAN-IN-CHIEF
JOHN M. T. FINNEY, M. D.
SURGEON-IN-CHIEF
J. WHITRIDGE WILLIAMS, M. D.
OBSTETRICIAN-IN-CHIEF
JOHN HOWLAND, M. D.
PEDIATRICIAN-IN-CHIEF
ADOLF MEYER, M. D.
PSYCHIATRIST-IN-CHIEF
WILLIAM G. MACCALLUM, M. D.
PATHOLOGIST

RECEIVED JUL 22 1924

July 21, 1924.

Dr. C. Hampsen Jones,
Commissioner of Health,
Baltimore, Md.

Dear Sir:

I desire to correct data on the death dertificate of Ruth Hooper, white, aged 7 months, signed by me July 20, 1924. The cause of death should read: Diarrhea, not dysentery, of three weeks' duration, instead of dysentery(unidentified) of 5 days' d duration.

Trusting that my errot does not cause much trouble, I am

Respectfully yours,

Edmund A. Kuper

D 88803

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 88803

REGISTERED NO. C 129

1-PLACE OF DEATH Home for the Aged, of the M. E. Church

CITY OF BALTIMORE (No. 400 N. Fulton Ave. ST.; 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Frances Kniskern

(Residence in Baltimore: No. Home for the aged of the M. E Church ST.; 35 yrs. ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Aug 16, 1848 (Month) (Day) (Year)

7-AGE: 75 yrs. 11 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Vermont.

PARENTS

10-NAME OF FATHER: Wm. Dudley Hoyt.

11-BIRTHPLACE OF FATHER (State or country): Vermont.

12-MAIDEN NAME OF MOTHER: Elizabeth Brown.

13-BIRTHPLACE OF MOTHER (State or country): New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave.

15 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

AUG 21 1924

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 20 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1924, to July 20 1924, that I saw her alive on July 18, 1924, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ✓ yrs. ✓ mos. 8 ds

Contributory (SECONDARY) chronic Nephritis.

(Duration) 2 yrs. ✓ mos. ✓ ds.

(Signed) George E. Shannon M. D.

July 20, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cem

DATE OF BURIAL: July 22, 1924

20-UNDERTAKER: George J. Smith & Colwell

ADDRESS 1532

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88804

CERTIFICATE OF DEATH.

185 D 88804

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2648 Maryland ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan W Ellinger

(Residence in Baltimore: No. 2648 Maryland St.; 6 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July 9, 1844
(Month) (Day) (Year)

7-AGE, 83 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob Zentmyer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Fitch

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Tete Barr

(Address) 2648 Maryland Ave

15- Filed JUL 21 1924, 191.. Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July - 21, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1924, to July 21, 1924, that I saw h[illegible] alive on July 21 1924, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fracture L Neck

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L G Richards M.D.

July 23, 191.., (Address) 612 W 20 St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

Fracture L Neck

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Waynesboro Pa	July 23, 1924
20-UNDERTAKER George J Smith	ADDRESS 1512 Hollins St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88805

CERTIFICATE OF DEATH.

101-001

D 88805

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2004 N. Smallwood St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Minnie Rosenberg

(a) Residence No. 2004 N. Smallwood St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 83 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER Israel Blum

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant) S. Rosenberg

(Address) Cambridge Ohio

15-

JUL 22 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 21 24

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to July 21, 1924, that I last saw h.. alive on July 21, 1924, and that death occurred, on the date stated above, at 1309 m.

The CAUSE OF DEATH* was as follows:

Hypertension

Hypocardiatis

Lobar pneumonia (Terminal)

(Duration) 12 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lobar pneumonia (Terminal)

(Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of.....

Was there an autopsy? none

What test confirmed diagnosis? Physical Examination

(Signed) Manuel B. Helman M. D.

7/27, 1924 (Address) 926 W. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lutheran Washington Rd

DATE OF BURIAL, 7/24, 1924

20-UNDERTAKER Adolf Levinson & Bro

ADDRESS 1124 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88806

REGISTERED NO. D 88806

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (NO. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Krause

(a) RESIDENCE NO. 1715 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Krause

6 DATE OF BIRTH (month, day, and year) Feb 17 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Quastmann

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Hosp. Record
(Address)

15 Filed JUL 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to July 20, 1924,
that I last saw her alive on July 20, 1924,
and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Hubert Wilkerson, M. D.

(Address) West Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	7-24-1924

20 UNDERTAKER Wm. C. & G. Rhode ADDRESS Govans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hermon. 7112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88807

CERTIFICATE OF DEATH.

164 D 88807

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1322 S Charles ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie M. Deibel

(a) RESIDENCE NO. 1322 S Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~Married~~, widowed, ~~or divorced~~ ~~(HUSBAND of~~ (or) WIFE of George F. Deibel

6 DATE OF BIRTH (month, day, and year) Nov 3rd 1829

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
94	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. John Muckly
(Address) 1322 S Charles St

15 Filed JUL 22 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19-1924

17

I HEREBY CERTIFY, That I attended deceased from over 10 years, to July 19, 1924, that I last saw h~~e~~ alive on July 18, 1924 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? usual

(Signed) G. Lafette Ewell M. D.

7/21, 1924 (Address) 2945 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	7-22 1924
20 UNDERTAKER	ADDRESS
Mrs Chas A G Rohde	600 W. Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMO[illegible]

D 88808

CERTIFICATE OF DEATH.

D 88808

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1729 E Hanover ST., 8 WARD)

2-FULL NAME Louisa Louis

(a) RESIDENCE No. 1729 E Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Mulatto	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C Herman Louis

6 DATE OF BIRTH (month, day, and year) April 29 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Christopher Leubner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Muhly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Lula. Louis

(Address) 1729 Hanover St

15 Filed JUL 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1924

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1924, to July 21, 1924, that I last saw h[illegible] alive on July 21, 1924, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Lungs

about 12 hours.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) apoplexy.
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Usual.

(Signed) G. Lafayette Ewalt M. D.

July 21 1924 (Address) 2945 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woods. Druid Hill Pk. DATE OF BURIAL 7-23 1924

20 UNDERTAKER Wm Chas A & J Kohler ADDRESS 600 N Arlington Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

88809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 106 N. Wolfe St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbra Reinsfelder

(a) Residence No. 106 N. Wolfe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Reinsfelder

6-DATE OF BIRTH (month, day and year) Sep 29 1839

7-AGE. 85 yrs. 10 mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Riehl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Chrysanzia Riehl

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Barbara Reinsfelder

(Address) 106 N. Wolfe

15- Filed JUL 21 1924 ROBERT N. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 21 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 19 24 to July 21 19 24

that I last saw h.. alive on July 20 19 24

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Fred Rupprecht M.D.

July 21 1924 (Address) 800 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	July 24 1924
20-UNDERTAKER.	ADDRESS
Wendell Dyfel & Son	378 Conn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Droicchio

D 88810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 900 Fawn St St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Matteo Elisa Droicchio

(a) Residence No. 900 Fawn St St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ..... Child

6-DATE OF BIRTH (month, day and year) December 26 1915

7-AGE. ..... 8 ..... yrs. ..... 6 ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Nicholas Droicchio

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Rachela Ruggieri

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14- (Informant)..... Nich Droicchio

(Address)..... 900 Fawn St

15- JUL 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-20-1924

17- I HEREBY CERTIFY, That I attended deceased from 7-17- 1924 to 7-20 1924

that I last saw h.im alive on 7-20- 1924

and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic

Myocarditis -

(Duration) ..... yrs. ..... mos. 5 ..... ds.

CONTRIBUTORY (Secondary) Acute Rheumatic myocarditis

(Duration) ..... yrs. ..... mos. 5 ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? NW Date of.....

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) S. D'Emanco M. D.

7-22 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Vincents	July 23 1924

20-UNDERTAKER.	ADDRESS.
Randall Geppert & Son	22 Lloyd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88811

CERTIFICATE OF DEATH.

109-002

D 88811

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1961 Patterson Place St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Riordan

(a) Residence No. 1961 Patterson Place St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Thomas Riordan

6-DATE OF BIRTH (month, day and year) May 20 188[illegible]

7-AGE. 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Adam Carr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Cath. Doyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14- (Informant) Cath. Carr

(Address) 1961 Patterson Place

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 20 1924

17- I HEREBY CERTIFY, That I attended deceased from June 17, 1924 to July 20, 1924, that I last saw h[illegible] alive on July 19, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Vincents Angina

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General Septicaemia

Puerperal Streptococcic (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? 941 Fremont Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) James McFarland, M. D.

July 24 1924 (Address) 701 E Chase

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	July 23 1924
20-UNDERTAKER.	ADDRESS
Geo M. Fonk & Son	811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88812

REGISTERED NO. 197 D 88812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mathilda Koehne

(a) RESIDENCE No. 1635 N. Patterson Park ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm.E.Koehne

6 DATE OF BIRTH (month, day, and year) 5/20/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

037

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Muhlhauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Koehne (son).
(Address) 1635 N. Patterson Pk Ave

15 JUL 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22/24 21 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen'l. Peritonitis- Pistol shot wound-Homicide (Inquest to be held July 23/24)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Carter, M. D.
(Coroner)

7/22/24 192 (Address) 508 E.Nprth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 7/23 1924

20 UNDERTAKER Albert L Hiltz Jr

ADDRESS 1606 N Chest

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88813 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88813

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1718 N Smallwood St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A Herr

(a) Residence No. 1718 N Smallwood St. Ward 17235

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-Single, Married, Widowed, Divorced Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Herr

6-DATE OF BIRTH (month, day and year) April 26, 1883

7-AGE 41 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Junk Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto City

PARENTS.

10-NAME OF FATHER Leopold Herr

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Emma Ruckel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Mary Herr (Address) 1718 Smallwood

15- JUL 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 11 1924 to July 20 1924

that I last saw h. alive on July 19 1924

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

probably (Duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? dont Know

Did an operation precede death? O Date of

Was there an autopsy? O

What test confirmed diagnosis? Sputum examination

(Signed) Martin J Hoare, M. D

7.22. 1924 (Address) 414 Prof. Bldg

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer | DATE OF BURIAL. July 23 1924

20-UNDERTAKER W Edkey & Sons | ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88814

CERTIFICATE OF DEATH.

15-91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4134 Forest Park Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda M. Hartzell

(a) Residence No. 4134 Forest Park Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John William Hartzell

6-DATE OF BIRTH (month, day and year) Feb. 10, 1844

7-AGE. 80 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Carroll Co. Md.

PARENTS.

10-NAME OF FATHER. Lovelace Gorsuch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Do not know

12-MAIDEN NAME OF MOTHER. Rachel Shipley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll Co. Maryland

14-Informant. Mrs. Estelle H. Marshall

Address 4134 Forest Park Avenue

15-Filed JUL 22 1924 FOREST R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 20th, 19.24 to July 19th, 19.24,

that I last saw h.....alive on July 19th, 19.24,

and that death occurred, on the date stated above, at 11:35 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken cardiac compensation, 3 m x d. duration (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis? X

(Signed) Estelle C. Price M. D

, 19 (Address) 1705 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	7/22, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88815 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2107 Chelsea Terrace St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Caldwell

(a) Residence No. 2107 Chelsea Terrace St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 0 mos. 9 ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: William Q. Caldwell

6-DATE OF BIRTH (month, day and year): July 10, 1841

7-AGE: 83 yrs. 0 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS

10-NAME OF FATHER: James B. Mannan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa.

12-MAIDEN NAME OF MOTHER: Martha Herbert Claiborne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14- (Informant): Mrs. Cora Caldwell Barker
(Address): 2107 Chelsea Terrace

15- JUL 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1918 to July 1924, that I last saw h.. alive on July 19, 1924 and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. G. Queen M. D.

, 19 (Address) 501 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 7/22, 19 24

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001 D 88816

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 24 WARD)

2-FULL NAME John Henry

(a) RESIDENCE No. 1424 Cookie ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Henry

6 DATE OF BIRTH (month, day, and year) July 6 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore 074

(c) Name of employer ~~Federal~~.

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Patrick Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Fitzmorris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hospital Record

15 Filed JUL 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/24

17 I HEREBY CERTIFY, That I attended deceased from 6/27/24, 19..., to 7/19/24, 19..., that I last saw h[illegible]live on 7/19/24, 19..., and that death occurred, on the date stated above, at 7:50 m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Port of Baltimore

Did an operation precede death? Yes Date of 6/29/24

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) R. Ca. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 23 1924

20 UNDERTAKER J. Wm. J. Fields ADDRESS 1200 W. Lombard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH INK. This is a permanent record.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 33817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 33817

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 628 E. 28th Street. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Nathaniel Paca.

(Residence in Baltimore: No. 628 E. 28th Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, September 10, 1923.
(Month) (Day) (Year)

7-AGE, yrs. 10 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Paca.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Catherine Barrett.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Paca.

(Address) 628 E. 28th Street.

JUL 22 1924 Filed, 191. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21/24, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to hi death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) convulsions

(Duration) yrs. mos. ds.

(Signed) J. S. Cole M. D.
(Coroner.)

7/22/24, 191... (Address) 508 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Baltimore Towson

DATE OF BURIAL, July 22, 1924

20-UNDERTAKER E. E. Roy Stuffler

ADDRESS 1255 North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 88818 (Johns Hopkins Hospital).

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bill

(a) RESIDENCE No. 1036 N Durham ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Bill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital.

15 ... Burial Permit Clerk.

JUL 22 1924

1621

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to April 23, 1924, that I last saw him alive on April 23, 1924 and that death occurred, on the date stated above, at 10 55 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C H Duncan, M. D.

4/24, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL 19

20 UNDERTAKER ROBERT R. KRAUTER, [illegible] Health.

ADDRESS .....

JUL 22 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88819

CERTIFICATE OF DEATH.

162 D 88819

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Greene 11 WARD)

2-FULL NAME Baby Johnson.

(a) RESIDENCE NO. 1204 Martin ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-15-24.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) University Hosp. Balto., Md.

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Edith Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County, Md.

14 Informant Edith Johnson
(Address) 1204 Martin St

15 Filed JUL 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk

1623

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-15, 1924, to 7-20, 1924, that I last saw him alive on 7-20, 1924, and that death occurred, on the date stated above, at 10 33 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no.

What test confirmed diagnosis?.....

(Signed) M. Alexander Mowey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

JUL 22 1924

Commissioner of Health.

Asst. Wm. R. Houssel

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88820

100-001

CERTIFICATE OF DEATH.

D 88820

1-PLACE OF DEATH

City of BALTIMORE: (No. 521 Colvin St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Boswell William

(a) Residence No. 521 Colvin St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. ....yrs. 3 mos. ....ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer) ~ None

(c) Name of employer ~

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant).....

(Address).....

15- Filed JUL 22 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20-24

17- I HEREBY CERTIFY, That I attended deceased from July 19- 1924 to July 20 1924 that I last saw him alive on July 20 1924 and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Dr. B. W. Kennard M. D

7-21 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL DATE OF BURIAL, ... 19....

20-UNDERTAKER. ADDRESS JUL 22 1924

Commissioner of Health.

For Wm. R. WOODALL

1626

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7716

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88821 CERTIFICATE OF DEATH. 135 D 88821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 10 WARD)

2-FULL NAME Chas. Brueverty.

(a) RESIDENCE NO. 1018 Forest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white.	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Maine.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Record.
(Address)

15 Filed ....., 19.... ROBERT A. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/24

17 I HEREBY CERTIFY, That I attended deceased from 7/1/24, 19...., to 7/19/24, 19....

that I last saw h[illegible] alive on 7/19/24, 19....

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 7/11/24

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. W. Holly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL AUG 22 1924

20 UNDERTAKER ADDRESS

(Director of Health, Directors and Morticians Act) 1627 Buried Mt Carmel Aug 22-1924 Jno Mus K & Fink

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Lauren St., 14 WARD)

2-FULL NAME Mary F. Thompson

(a) RESIDENCE No. 532 Laurens St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence Justice

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elva Thompson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Elva F. Thompson
(Address) 532 Laurens St.

Filed JUL 2 21924 ROBERT R. KRAUTER, Registrar

ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lob - entertis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

July 21, 1924 (Address) 27 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	July 22 1924
20 UNDERTAKER	ADDRESS
Jesse Redden	456 Biddle St

Cor.—1-12-25—M&T—100 Bks.

D. 88822 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 88822

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Laurens St. 14 WARD)

2-FULL NAME Mary Thompson

(a) RESIDENCE NO. 532 Laurens St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed JUL 22 1924, 192 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro - enteritis

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. T. Hennessey, M. D.
(Coroner.)

(Address) 2102 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 7/23 1924

20 UNDERTAKER Jesse Riddick

ADDRESS .....

INSTRUCTIONS.—WRITE PLAINLY, WITH UNFADING INK. PENCIL MARKS WILL NOT REPRODUCE. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88823 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 88823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Bertha L Davis St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1718 Ashland ave

(a) Residence No. 1718 Ashland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: Colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 4 - 1918

7-AGE: 5 yrs. 8 mos. 15 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS

10-NAME OF FATHER: Jack Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country): V. C.

12-MAIDEN NAME OF MOTHER: Jessie Eaton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) Jessie Davis

(Address) 1718 Ashland ave

15- JUL 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 19 1924

17- I HEREBY CERTIFY, That I attended deceased from July 4 1924 to July 19 1924 that I last saw h[illegible] alive on July 19 1924 and that death occurred, on the date stated above, at 8 P.M. The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged heart

Indefinite (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Fisher M. D.

7-21, 1924 (Address) 1614 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	July 22
20-UNDERTAKER,	ADDRESS
Mark C Elliott	725 Eastland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAK

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88824

CERTIFICATE OF DEATH.

128 D 88824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 450 E Federal St., 17 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shannar Bouldin

(a) RESIDENCE NO. 450 E Federal St., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Bouldin

6 DATE OF BIRTH (month, day, and year) August 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jenkins Contractor

9 BIRTHPLACE (city or town) (State or country) Gloucester Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Annie Johnson
(Address) 2258 Homestead

15 Filed JUL 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 19, 1924.

that I last saw h alive on July 14, 1924.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis Pneumonia
Hypostatic and Gastritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Dall, M. D.

, 19 (Address) 1126 E 3 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 29 24
20 UNDERTAKER	ADDRESS
Moore & Elbert.	725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88825 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88825

X 118-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2-FULL NAME Edmund E. Chilcoat.

(a) RESIDENCE NO. Reisterstown ... Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~X~~ yrs. mos. 1 ds. How long in U. S., ~~If of foreign birth~~? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of Mrs. Chilcoat.
(or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Oct. 2-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore County.

PARENTS

10 NAME OF FATHER George Chilcoat.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County.

12 MAIDEN NAME OF MOTHER Josephine Griffith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County.

14 Informant (Brother, Kay Chilcoat) (Address) 2200 Brookfield Ave.

15 Filed ROBERT R. KRAUTER, Registrar
JUL 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to July 20, 1924, that I last saw him alive on July 20, 1924, and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Right Temporal Uremia. 10 years.
Strangulated Hernia. 3 days.
(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction,
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 20/24

Was there an autopsy? .....

What test confirmed diagnosis? By Operation.

(Signed) Wm A Stamper M.D.

, 19 (Address) Md General Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wm C Brooks Baptist Friend Meeting House

DATE OF BURIAL July 23 1924

20 UNDERTAKER .....

ADDRESS Sparks Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88826

CERTIFICATE OF DEATH.

179 D 88826

1-PLACE OF DEATH South Balto. Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William White

(a) RESIDENCE No. 2334 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia J. White

6 DATE OF BIRTH (month, day, and year) Jan. 17-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jos. T. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Peggy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Charles R. White

(Address) 1123 Eutaw Place

15 UL 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to July 22, 1924, that I last saw h alive on July 21, 1924 and that death occurred, on the date stated above, at 1:15 A. m.

The CAUSE OF DEATH* was as follows:

Ischio Rectal Abscess with Extravasation of Urine & Chr. Cystitis & Nephritis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) William B Dacen M. D.

July 22 1924 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 24 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	220 Fulton Ave.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 88827

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3403 Claremont St. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edwin Chester

(a) Residence No. 3403 Claremont St St., 26 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Chester.

6-DATE OF BIRTH (month, day and year) Dec. 25-1844

7-AGE. 79 yrs. 6 mos. 26 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Gardner.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS:
10-NAME OF FATHER, Michael Chester
11-BIRTHPLACE OF FATHER (city or town) (State or Country), England.
12-MAIDEN NAME OF MOTHER, Hannah Crosslin
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14-
(Informant) Mary C. Chester
(Address) 3403 Claremont St.

15-
Filed JUL 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 21-1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to July 20 1924 that I last saw him alive on July 20 1924, and that death occurred, on the date stated above, at 7.35 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(Duration) 2 yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Stricture of Esophagus

(Duration) 14 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. M. Scheeder M. D

July 24 1924 (Address) 330 N. Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: July 24 1924

20-UNDERTAKER: Lilly & Zeiler ADDRESS: 1103 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88828

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2694 Wilkens Ave. 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah M. McCormick

(a) Residence No. 2694 Wilkens Ave St., 20 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late John McCormick

6-DATE OF BIRTH (month, day and year) aug 31st 1869

7-AGE. 54 yrs. 10 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Thomas Gloster

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Brosnan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-

(Informant) Mary L. Gloster.

(Address) 2694 Wilkens Ave

15-

Filed JUL 22 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 20th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to July 20 1924

that I last saw h... alive on July 19 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intercurrence

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?* Physical

(Signed) Robert F. Blake M. D

July 21 1924 (Address) 21 Wilkens Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	July 23rd 1924
20-UNDERTAKER. Lilly & Zeiler	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 88829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 26 WARD)

REGISTERED NO. 144

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Hahn

(a) RESIDENCE NO. 3431 E. Lombard ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. Hahn.

6 DATE OF BIRTH (month, day, and year) Jan 29 1883

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Emanuel Botarde

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Hanka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George T. Hahn.
(Address) 3439 E. Lombard St.

15 Filed July 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to July 21, 1924, that I last saw her alive on July 21, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral anemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 18 1924

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Leibott Hebrew Hospital, M. D.

July, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 23 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 1038 Hollins

Spec.—1-10-21—M&T—1500 Bks.

D 88830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88830

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E Fort ave ST. 24 WARD)

James H. King

2-FULL NAME Jos H King

(a) RESIDENCE No. 319 E. Fort ave ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 6-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	62	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rachel R Rondall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ann King

(Address) 319 Fort ave

JUL 22 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to July 21, 1924, that I last saw him alive on July 19, 1924, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Volvular Heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthenia cardiac Incompetency

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) W B Hall M. D.

, 19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 7/23/1924

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1460 Battery Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 8883F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8883F

CERTIFICATE OF DEATH.

X 188-003

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St. 11 WARD)

(If death occurred in a hospital or institution, give NAME instead of street number and fill out No. 18.)

2-FULL NAME Louis B. Ridgley

(a) RESIDENCE NO. [illegible] West Friendship Md. WARD

(Usual place of abode) B. C. H.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Ridgely

6 DATE OF BIRTH (month, day, and year) Sept 25 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Worthington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Ridgely West Friendship Md.
(Address)

15 Filed JUL 22 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 192[illegible]

17 I HEREBY CERTIFY, That I took charge of remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos. 2

CONTRIBUTORY (Secondary) Automobile accident (duration) yrs. mos.

(Signed) E. J. Harmony, M. (Coroner.)

July 22, 1924 (Address) 710 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ...

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cem. DATE OF BURIAL July 23 192[illegible]

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88832

CERTIFICATE OF DEATH.

31 D 88832

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Dorsey

(Residence in Baltimore: No. 2327 Division St.; ....yrs. 1 mos. ....ds.

Born in Balt. md 2 1923

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December, 9, 1893
(Month) (Day) (Year)

7-AGE, 31 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): 023

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Hall

13-BIRTHPLACE OF MOTHER (State or Country) Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Dorsey

(Address) 2327 Division St.

15-

JUL 23 1924 ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July, 19, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1924, to July 19 1924, that I saw h.. alive on " " 1924 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) T. E. Daugherty M. D.

July 20, 1924 (Address) 602 Poultney St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 23, 1924

20-UNDERTAKER Joseph A Farrell — ADDRESS 2319 Division

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88833

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 244 S Wolf St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Laurence Catherine V. S.

(Residence in Baltimore: No. 244 S Wolf St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov (Month) 15 (Day) 1861 (Year)

7-AGE.	If LESS than 1 day,
62 yrs. 8 mos. 6 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. Andrew Cement

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Barbara Hafer

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Cement

(Address) 244 S Wolf St

15- JUL 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day) 1924 (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. W. Kerr M. D. (Coroner.)

July 24 1924 (Address) 700 Cathedral

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	July 24 1924

20-UNDERTAKER.	ADDRESS
Lilly & Zeiler	30 S. Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88834

CERTIFICATE OF DEATH.

57 D 88834

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4014 Liberty Heights Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Ann Lemke

(a) Residence No. 4014 Liberty Heights Ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Lemke

6-DATE OF BIRTH (month, day and year) Nov. 7. 1855

7-AGE. 68 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Zimmerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Mary Steilberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) George Lemke

(Address) 4014 Liberty Heights Ave

JUL 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-21-24

17- I HEREBY CERTIFY, That I attended deceased from 1922 19.. to 7-21 19 24

that I last saw her alive on 7-22 19 24

and that death occurred, on the date stated above, at 9 45 XX m.

The CAUSE OF DEATH was as follows:

Diabetes

Acute Paresis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Cardelitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Krauer M. D.

7/27 19 24 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oaklawn Cem	7/24 1924
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88835 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88835

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 726 N. Gay St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca Lebrun

(a) Residence No. 726 N. Gay St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General natnre of industry, business, cr establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Abraham Hutterman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Mrs. Levin

(Address) 726 N. Gay st

15- Filed JUL 23 1924 192.. HUBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/22/24

17- I HEREBY CERTIFY, That I attended deceased from July 19 1924 to July 22 1924

that I last saw h.e alive on July 22 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-cerebritis uraemia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. A. H. A. Meyer M. D.

July 22, 1924 (Address) 2438 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rising Sun — DATE OF BURIAL, 7/23 1924

20-UNDERTAKER. Sol Levinson & Bro — ADDRESS 1624 E. Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88836 | 100 001 | D 88836

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2102 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J Sebode

(a) Residence No. 2102 Fleet St., 1 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar-19-1924

7-AGE. ....yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John Sebode

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Frances Zapalowicz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Barbara Zapalowicz

(Address) 2102 Fleet St

15- JUL 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22-24

17- I HEREBY CERTIFY, That I attended deceased from June 15 1924 to July 22 1924 that I last saw h[illegible] alive on July 22 1924 and that death occurred, on the date stated above, at 5-30 P.M. The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho. pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.S. & Symptoms

(Signed) John J. Krogeth M. D

, 19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet Cemetery	July 24 1924
20-UNDERTAKER.	ADDRESS
Stephen J Fialkowski	1000 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88837 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88837

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 414 E. Biddle St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Florence G. MacWhinnie

(a) Residence No.... 414 E. Biddle St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Herbert C. MacWhinnie

6-DATE OF BIRTH (month, day and year) May 3-1879

7-AGE, 45 yrs. 2 mos. 19 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... House
(b) General nature of industry, business, or establishment in which employed (or employer)... Work
(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.
10-NAME OF FATHER, Jos. R. Thompson
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Catherine A Filpatrick
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Herbert C. MacWhinnie
(Address) 414 E. Biddle St

15- Filed....., 192.. ROBERT R. KRAUTER, Registrar.
JUL 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22-1924

I HEREBY CERTIFY, That I attended deceased from June 19, 1924 to July 22, 1924
that I last saw her alive on July 22, 1924
and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Primary: Pineal Sarcomatosis
about 1½
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asthma
(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam

(Signed) Leonard McCarthy M. D.
192.. (Address) 111 St Paul Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral | DATE OF BURIAL, July 25, 1924

20-UNDERTAKER, Jd. C. Wedefeld 9 | ADDRESS 4 Greenmt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88838

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 Madison Ave 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fannie E. Ash

(a) Residence No. 1516 Madison Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Aug 18 1851~~

6-DATE OF BIRTH (month, day and year) Aug 18th 1851

7-AGE. 72 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS

10-NAME OF FATHER, Louis Ash

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Erna Gutman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) David Ash

(Address) 1516 Madison Ave

15-

Filed JUL 23 1924

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22/24

17- I HEREBY CERTIFY, That I attended deceased from June, 1924, to July 22, 1924, that I last saw h.. alive on June 22, 1924, and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

Pernicious anemia Chronic myocarditis.

Contributory (Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis hypertension

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? None

What test confirmed diagnosis? physical signs

(Signed) [illegible] M. D.

, 19 (Address) 9 E. Lexington St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Har Sinai

DATE OF BURIAL. July 24th 1924

20-UNDERTAKER. David Sondheim

ADDRESS 118 N Eutaw Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

88839 B

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88839

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS H[illegible]

CITY OF BALTIMORE: (NO. ..... ST., ? WARD)

2-FULL NAME Mrs Sarah Alford

(a) RESIDENCE NO. St. Albans Tyaro St, WARD. W. Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: Albert McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Martha Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 23 1924, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 23, 1924, that I last saw h[illegible] alive on July 23, 1924, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Toxic adenoma of thyroid,
Myocardial insufficiency.

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St albans W Va — DATE OF BURIAL: July 23, 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 220 B Way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Wernicke.

D 88840 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88840

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 S Clinton ST., 16 WARD)

2-FULL NAME John. A Wernicke

(a) RESIDENCE NO. 223 S Clinton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Wernicke

6 DATE OF BIRTH (month, day, and year) June 17 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) United R R. 8 01

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Wernicker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Agnes Schnorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adelaide Wernicker (Address) 223 S Clinton St

15 JUL 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1924 to 7-21, 1924 that I last saw h.i.v. alive on 7-09, 1924 and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Toxemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

7/24/24 (Signed) L J Frame M. D.

, 19 (Address) 1439 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	7-24, 1924

20 UNDERTAKER Erb Harle ADDRESS 115 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88841 **CERTIFICATE OF DEATH** Hamilton D 88841

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Glenmore & Oakland St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester F. Taylor

(a) Residence No. Glenmore Oakland St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John O. Taylor

6-DATE OF BIRTH (month, day and year) Sept 4 1843

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm Bryan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) John O. Taylor

(Address) Hamilton Md

15- JUL 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924 to July 21 1924

that I last saw her alive on July 21 1924

and that death occurred, on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Beaugh Long M. D.

July 22 1924 (Address) 2717 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Catonsville Md

DATE OF BURIAL. July 24 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88842

D 88842

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E. 20th ST., 9 WARD)

2-FULL NAME Frances R. Collins

(a) RESIDENCE NO. 505 E. 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1

6 DATE OF BIRTH (month, day, and year) Dec 28th 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Michael J. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) America

12 MAIDEN NAME OF MOTHER Mary P. Collins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Bernard K. McGinn, (Address) 505 E. 20th St.

15 Filed JUL 23 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1924

17

I HEREBY CERTIFY, That I attended deceased from April 16th, 1923 to July 22nd, 1924, that I last saw h alive on July 22nd, 1924, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

unknown (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. of urine and Blood Pressure test

(Signed) Charles G. B, M. D.

July 24 19 24 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL July 25th 24

20 UNDERTAKER Chas F. Ernestson — ADDRESS 118 W. Mt. Royal ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(John A. Hespelein)

D 88843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88843

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital Bals. Md. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Brother Justus (John Hespelein)

(a) Residence No. Mt. St. Joseph's College St. Bals. Md Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 20, 1894

7-AGE. 29 yrs. — mos. — ds. (If LESS than 1 day, ...hrs. or....min.)

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Do not Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " "

14- (Informant) Brother Antoninus

(Address) Mt. St. Joseph's College

15- Robert P. Harrison, Registrar.

JUL 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 17th 1924 to July 22nd 1924, that I last saw him alive on July 22nd 1924, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uraemia)
Hypertension

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic cardio Renal Disease (Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H W Harper M. D

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	7/24 1924
20-UNDERTAKER. Fred A. Krauser Son.	ADDRESS 703 Hanover St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88844

CERTIFICATE OF DEATH.

1733 JOHNS HOPKINS HOSPITAL. X 90

1-PLACE OF DEATH

CITY OF BALTIMORE, No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Flacks

(a) RESIDENCE No. Jacksonville Fla ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Olga Flacks

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer .....—

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Flacks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Feinmire?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 23 1924, 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1924

17

I HEREBY CERTIFY, That I attended deceased from July 14 —, 1924, to July 22, 1924, that I last saw him alive on July 22 —, 1924, and that death occurred, on the date stated above, at 2 00 A m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis - ruptured aneurism - coronary embolism

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of July 22/1924

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jacques Cohn, M. D.

7/23 1924 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 7/23 1924

20 UNDERTAKER A. Levinson & Bro — ADDRESS 112 E Balto St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88845

D 88845

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH Colored Home & Infirmary

CITY OF BALTIMORE: (No. [redacted] ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted], Mr. Jacob H Leister

(a) RESIDENCE No. 2 Evergreen Ave., Hamilton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vila A. Leister

6 DATE OF BIRTH (month, day, and year) Mar. 9, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) B & O Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) Mt. Airey

(State or country) Maryland

PARENTS

10 NAME OF FATHER Israel B. Leister

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Margaret Armpriester

13 BIRTHPLACE OF MOTHER (city or town) York

(State or country) Pennsylvania

14 Informant Mrs. Jacob H. Leister

(Address) 2 Evergreen Ave.-Hamilton

15 Filed JUL 23 1924 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-1924

17

I HEREBY CERTIFY, That I attended deceased from 7-21, 1924, to 7-22, 1924,

that I last saw him alive on 7-22, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-21-24

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Henry V.P. Wilson Jr. M.D.

7-23-24 (Address) Colored Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL July 25 19

20 UNDERTAKER P. Block — ADDRESS 1005 Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [redacted] is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88846

CERTIFICATE OF DEATH.

129 D 88846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 3 WARD)

2-FULL NAME Mrs. May E. Young

(a) RESIDENCE NO. 10 S. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Young

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Charles F. Young

(Address) 10 S. Broadway

15 Filed JUL 23 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1924,

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 22, 1924, that I last saw her alive on July 22, 1924, and that death occurred, on the date stated above, at 1.52 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Gilbert, M. D.

7-23, 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trenton, New Jersey

DATE OF BURIAL July 25 1924

20 UNDERTAKER J. B. Cook

ADDRESS 1003 W. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 38847

CERTIFICATE OF DEATH

D 38847

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 5108 Wilson Avenue St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hubrta Irene Millard

(Residence in Baltimore: No. 5108 Wilson Avenue St.; ..... yrs. 11 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: April 13 (Month) (Day), 1917 (Year)

7-AGE: 7 yrs. 3 mos. 10 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer): Ohl

9-BIRTHPLACE (State or country): Indianapolis Ind.

PARENTS

10-NAME OF FATHER: Hubert I Millard

11-BIRTHPLACE OF FATHER (State or country): Consal Bluffs Iowa.

12-MAIDEN NAME OF MOTHER: Noma E. Flores Chisholm

13-BIRTHPLACE OF MOTHER (State or country): Cincinnatti Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hubert I. Millard

(Address) 5108 Wilson ave

15- JUL 23 1924 Robert P. Harrison, ... 191 ..... Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 23 — (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to, Jul 23 — 1924, that I saw h.. alive on Jul 22 — 1924, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis & Myocarditis

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), E. E. Nichols M. D.

Jul 23 1924 [Address] Physician Ind.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Indianapolis, Indiana

DATE OF BURIAL: July 24, 1924

20-UNDERTAKER: J. B. Cook

ADDRESS: 1003 W. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 88848

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Gray

(a) RESIDENCE. No. ? ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address)

15 Filed JUL 24 1924 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-20, 1924 to 7-21, 1924 that I last saw her alive on 7-21, 1924 and that death occurred, on the date stated above, at 5-50 p. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A. Dean, M. D.

7-21 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	7/24/24
20 UNDERTAKER	ADDRESS
J. J. Staley & Sons	1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88849

CERTIFICATE OF DEATH.

133 D 88849

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Oakley ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hutchinson Hawthorne

(a) RESIDENCE NO. 104 Oakley ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Rev J. B. Hawthorn

6 DATE OF BIRTH (month, day, and year) Feb 22 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Wm Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Hartwell H Hawthorne (Address) Charlottesville Va

15 JUL 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-4, 1924, to 7-23, 1924,

that I last saw h[er] alive on 7-22, 1924,

and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enterelitis following Cystitis resulting in shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Rayfield, M. D.

7-24, 1924 (Address) 3902 Greenland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hollywood Cem Richmond Va	7/25 1924
20 UNDERTAKER James. T Jonlson	ADDRESS 124 Grace St

Spec.—1-10-21—M&T—1500 Bks.

173383 JOHNS HOPKINS HOSP.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 38850

D 38850

CERTIFICATE OF DEATH. X 16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Holland

(a) RESIDENCE—NO. Dunkirk Apts. Brooklyn Md. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Sing'l

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Feb 16, 1924

7 AGE: Years —— Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Allen E. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mamie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Resident Johns Hopkins Hosp.

15 Filed JUL 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924 to July 23, 1924, that I last saw h[illegible] alive on July 23, 1924, and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery (~~Flexner~~) (bacillary)

Undetyfied (duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) A. A. Wreck M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: July 24 1924

20 UNDERTAKER: Joseph A Farrell ADDRESS: 2319 Dunsan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 8885I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 ✓ D 8885I

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mersey Hospital ST., 18 WARD)

2-FULL NAME Lennie Johnson -

(a) RESIDENCE No. 211 Rock st - ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colo	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None -
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Charles Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

PARENTS

14 Informant Jennie Johnson
(Address) 211 Rock st

15 Filed JUL 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia & Shock

(duration) ..... yrs. ..... mos. 2 0 ds.

CONTRIBUTORY (Secondary) Burns on body by hot water accidentally given (duration) ..... yrs. ..... mos. — ds.

(Signed) J. H. Engel, M. D. (Coroner.)

July 23, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 7/23 1924

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

BEFORE SIGNING BE CAREFULLY SURE THAT ALL ITEMS ARE CORRECTLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38852

CERTIFICATE OF DEATH.

5

D 38852

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 905 N. Duncan St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kostohryz

(a) Residence No. 905 N. Duncan St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Christina Kostohryz

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bohemia Bohemia

PARENTS.

10-NAME OF FATHER, John Kostohryz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Teresa Ernst

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14-Informant Christina Kostohryz

(Address) 905 N. Duncan St

15-Filed JUL 24 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 22/24

17-I HEREBY CERTIFY, That I attended deceased from July 10, 1924 to July 22, 1924

that I last saw him alive on July 22, 1924

and that death occurred on the date stated above at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Malaria

Bronco Pneumonia (Duration) 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Smear

(Signed) J. F. Weber, M.D.

11-22, 1924 Address 1001 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	July 26 1924
20-UNDERTAKER	ADDRESS
Frank Buchheister	1916 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 88853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Klapp Milnor

(a) RESIDENCE NO. 1014 N.Appleton St ST., 16 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? 66 yrs. 10 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V.Milnor

6 DATE OF BIRTH (month, day, and year) Sept.13-1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph K.Milnor

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER ? ? ? ?

13 BIRTHPLACE OF MOTHER (city or town) ? ? ? (State or country) ? ? ?

14 Informant Frank B. Milnor -(Son)
(Address) 3507 Copley Road-Ashburton

15 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk. JUL 24 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about 3 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Myocardial Degeneration

about 3 yrs. mos. ds. (duration)

(Signed) J. J. Hennessy, M. D. (Coroner.)

July 23 1924 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 24, 24

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM P. MOWEN, Successor)

ADDRESS [redacted]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 88854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1546 N. Fremont Ave ST., 45 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Dohman

(a) RESIDENCE NO. 1546 N. Fremont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Jacob~~ Joseph A. Dohman

6 DATE OF BIRTH (month, day, and year) about 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Alabama

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) .....

14 Informant Ida Nutt
(Address) 815 N. Eutaw St.

15 Filed JUL 24 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Heuisler M. D.
(Coroner.)

July 24, 1924 (Address) 218 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 24 192 4
20 UNDERTAKER Jesse Redden	ADDRESS 436 Biddle St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 88855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002

D 88855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Walnut Ave. ST., Overlea WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lee Schmidt

(a) RESIDENCE No. 202 Walnut Ave. ST., Overlea WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER William R. Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth C. Toepfner

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant William R. Schmidt (Address) Overlea Md.

15 Filed JUL 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6th, 1924, to July 23, 1924.

that I last saw h[illegible] alive on July 22, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale.
Blue Baby

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A. Fritz, M. D.

7/24/24, 19 (Address) Overlea, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	July 24 1924
20 UNDERTAKER Fred. Lasch & Sons	ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88856

D 88856

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Conner Ave + Dukeland ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillie Mae Emrick

(a) RESIDENCE NO. 134 Loudon Ave ST., 20 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Chas Emrick

6 DATE OF BIRTH (month, day, and year) June 16, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John M. Boswell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Boyd

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Charles Emrick
(Address) 134 Loudon Ave

15 JUL 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1924, to July 23, 1924, that I last saw her alive on July 23, 1924, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows: (Immediate Cause)
Acute Cardiac Dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus + Chr. Nephritis (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No clinical

What test confirmed diagnosis?

(Signed) Jas. Hobart Willmon, M. D.

, 19 (Address) West Balto Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem'y

DATE OF BURIAL July 25 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. Mondon

Spec.—1-10-21—M&T—1500 Bks.

D 88857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 88857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Orleans ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc. Sweeney

(a) RESIDENCE No. 2413 Orleans st. ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4/1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	60	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tanner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Dennis Mc Sweeny

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Sarah Mc Sweeney (Address) 2413 Orleans st.

15 Filed JUL 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 st 1922, to July 22, 1924, that I last saw h in alive on July 21, 1924 and that death occurred, on the date stated above, at 5-55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Descending colon

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Gen Carcinosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Oct 1 1922

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) M. J. M Lavoy, M. D.

(Address) 839 S. Ellwood Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: New Cathdral — DATE OF BURIAL: July 25 1924

20 UNDERTAKER: Jos. J. Merr — ADDRESS: 156 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88858

CERTIFICATE OF DEATH.

D 88858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josepu Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj. Gilbert Grantland

(a) RESIDENCE NO 311 E. Hamburg St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Mar 17/1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Chas. H. Grantland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER Bessie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant Chas. H. Grantland
(Address) ~~311 E. Hamburg St~~

15 JUL 24 1924

16 ROBERT R. KRAUTER, (Registrar)
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Peritonitis-Ruptured appendix. (Operation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Paul, M. D.
(Coroner.)

7/23/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	July 25 192 4

20 UNDERTAKER: F. A. Krause & Son ADDRESS 703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88859

CERTIFICATE OF DEATH.

46 D 88859

1-PLACE OF DEATH

City of BALTIMORE: (No. 302 Wyndhurst Ave. Ward) 27

Registered No.....

2-FULL NAME Mary R. Floyd.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 302 Wyndhurst Ave St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country) St Marys Co Md

PARENTS.

10-NAME OF FATHER Wm G. Floyd

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary E. Mills

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Catherine E. Floyd

(Address) 302 Wyndhurst Ave

JUL 24 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23 1924

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to July 23, 1924, that I last saw h[illegible] alive on July 23, 1924, and that death occurred, on the date stated above, at 6 17 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? about 6 mos ago

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Watson M. D.

July 24, 1924 (Address) 2128 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. July 26, 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W Fayette St

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88860

CERTIFICATE OF DEATH.

D 88860

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3122 O'Donnell St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jamusch

(a) Residence No. 3122 O'Donnell St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If ~~married~~, widowed, ~~or divorced~~ HUSBAND ~~of~~ (or) WIFE of Caroline

6-DATE OF BIRTH (month, day and year) April 4-1835.

7-AGE. 89 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Conrad Jamusch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Yetta Jamusch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Margaret H. Jamusch

(Address) 3122 O'Donnell St

15- Filed JUL 2 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23. 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to July 23 1924

that I last saw h. ~~im~~ alive on July 23 1924

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace P. Fitchew M. D.

7/23. 192X (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cem	July 25 19 24
20-UNDERTAKER	**ADDRESS**
Zirkler + Zirkler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88861 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88861

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital 8 31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma White

(a) Residence No. 2222 E. North avenue St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1904

7-AGE. ....20...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. B.L. Speight

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William White

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Lizzie Holbrook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital records

(Address) M.T.H.

Filed JUL 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 21,1924

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to July 21, 1924, that I last saw her alive on July 21, 1924, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5-23-24 Ruptured appendix

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Sputum

(Signed) J. F. White M. D.

7-22- 1924 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Pisgah Eastern Shore	July 24
20-UNDERTAKER	ADDRESS
Mark C. Elliott	July 24/24

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 88862

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 Bevan Street. ST., 27 WARD)

2-FULL NAME Louis Freeman. (C)

(a) RESIDENCE No 829 Bevan Street. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Burdella Saunders. (C).
(Address) 829 Bevan St.

JUL 24 1924

Filed ..... 192 ROBERT R. KRAUTER, Registrar

1631 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

July 23, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	192 JUL 23 1924
20 UNDERTAKER	ADDRESS

REMARKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88863

CERTIFICATE OF DEATH.

47 D 88863

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 664 W Saratoga ST., 4 WARD)

2-FULL NAME Alice Evans

(a) RESIDENCE No. 664 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Thomas Evans

6 DATE OF BIRTH (month, day, and year): Dec 20, 1885

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or min.
39	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Snow Hill Md

PARENTS

10 NAME OF FATHER: John Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nancy Hutchins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Thomas Evans

(Address): 664 W Saratoga St.

15 Filed JUL 24 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924 to July 22, 1924 that I last saw h e alive on July 21, 1924 and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration)* yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Carcinoma of Breast

(duration) 2 yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Howard M. D.

1924 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL July 24 24

20 UNDERTAKER: Samuel Wensley ADDRESS 1128 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88864

D 88864

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 914 Fear st St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... David A. Brown

(a) Residence No..... 914 Fear st St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Agnes E. Brown

6-DATE OF BIRTH (month, day and year) May 20 1849

7-AGE, 75 yrs. — mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Junk dealer

(b) General nature of Industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Louis Brown

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Strauss

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country),

14-

(Informant) Mary L. Brown

(Address) 1538 Wilmer Alley

15-

Filed ..... 192.. ROBERT R. KRAUTER Registrar.

OCT 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 21 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... May 9 ..... 19 24 ..... to ..... July 21 ..... 19 24 .....

that I last saw him alive on ..... July 21 ..... 19 24 .....

and that death occurred, on the date stated above, at ..... 9.0P ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Edward E. Wagner M. D.

7 28, 1924 (Address) 914 Fear st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Cem DATE OF BURIAL, July 24 1924

20-UNDERTAKER, Samuel T. Kemsley ADDRESS 528 N Bdle

I. S. WHITE LABEL, White Ground, Black Ink. Size 3½ x 5½ inches. Printed EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88865

CERTIFICATE OF DEATH.

47 D 88865

REGISTERED NO.

1-PLACE OF DEATH Union memorial Hospital

CITY OF BALTIMORE: (No. 33rd ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Gass Henry

(a) RESIDENCE NO. 2701 Calvert ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND of~~ J. A. Henry

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) new York -

PARENTS

10 NAME OF FATHER George Garr

11 BIRTHPLACE OF FATHER (city or town) new York (State or country)

12 MAIDEN NAME OF MOTHER Eliza Kennedan

13 BIRTHPLACE OF MOTHER (city or town) new York (State or country)

14 Informant Mrs Smith (Address) 2701 N Calvert St

15 Filed JUL 24 19.. ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1924, to July 23, 1924, that I last saw her alive on July 23, 1924 and that death occurred, on the date stated above, at 11.20 p m.

The CAUSE OF DEATH* was as follows:

Streptococcus (hemolyticus) septicaemia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) 1 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of July 10. 1924

Was there an autopsy? no tissue sections.

What test confirmed diagnosis? Blood culture

(Signed) Donald Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark New Jersey

DATE OF BURIAL July 25 1924

20 UNDERTAKER Henry H Jenkins & Sons Co

ADDRESS Orchard & Collord Sts

Cor.—1-12-23—M&T—100 Bks.

D 88866 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital × 189

CITY OF BALTIMORE: (No. Franklin Square ST., 19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace S. Small

(a) RESIDENCE NO. Parkton, Md. ST., WARD Parkton Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work farmer. yo
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) York
(State or country) Pa

PARENTS

10 NAME OF FATHER Wm Small

11 BIRTHPLACE OF FATHER (city or town) York
(State or country) Pa

12 MAIDEN NAME OF MOTHER Harriet Emerson

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country) Pa

14 Informant Wm Small
(Address) Parkton Md

15 Filed JUL 24 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiryt) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yr. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Kicked by Horse

(duration) yr. mos. ds.

(Signed) Thos B. Norton, M. D.
(Coroner.)

July 23rd 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs., mos., 3 ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Parkton Md

Former or usual residence Parkton Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa — DATE OF BURIAL July 25 1924

20 UNDERTAKER Edw. Leod & Son — ADDRESS York Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 606 N. Pulaski St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Caine Cantell.

(a) Residence No. 606 N. Pulaski St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (~~Write the word.~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, about 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, — Fitzpatrick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Courtney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) daughter in Law

(Address) 606 N. Pulaski St

15- Filed JUL 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 23/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to July 21 1924

that I last saw h[illegible] alive on Dec 21 1924

and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Depletion

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Murray, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville Cemetery

DATE OF BURIAL, 7/25, 1924

20-UNDERTAKER, Wm Cook

ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88868

1-PLACE OF DEATH

City of BALTIMORE: (No. 2209 W. North Ave. St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sarah Rodberg,

(a) Residence No. 2209 W. North Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (write the word.): Widow,

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Simon I. Rodberg,

6-DATE OF BIRTH (month, day and year) Dec. 14, 1842

7-AGE: 81 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). England

PARENTS.

10-NAME OF FATHER, Emanuel Hynes

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), England,

12-MAIDEN NAME OF MOTHER, Rosa Samuels

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), England.

14-
(Informant) Mr. Rodberg
(Address) 2209 W. North Ave.

15-
Filed JUL 24 1924
Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/23/24.

17- I HEREBY CERTIFY, That I attended deceased from July 7— 1924 to July 23— 1924

that I last saw h.. alive on July 23 1924

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver —
(Hemic & Cardiac)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchs - Pneumonia —

(Duration) yrs. 3 mos. 3 wks

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank C Bruner, M. D.

July 24, 1924 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship Cem. DATE OF BURIAL, 7/25/ 1924

20-UNDERTAKER, David Sondheim ADDRESS 118-20 W. Mt. Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88869

CERTIFICATE OF DEATH.

× 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 732 Mc Henry St., 21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R. Walter

(a) Residence No. 732 Mc Henry St., Ward Penna Yorkerly

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret F. Walter

6-DATE OF BIRTH (month, day and year) Aug 26 1878

7-AGE. 45 yrs. 11 mos. 0 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager of Store

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Chas. E. Lumb Co Newport

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James E. Walter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Amelia Schultz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Robert J. Walter

(Address) 2217 E. Monument St.

15- FILED JUL 24 1924 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24 1924

17- I HEREBY CERTIFY, That I attended deceased from June 7th 1924, to July 24th 1924,

that I last saw him alive on July 24th 1924

and that death occurred, on the date stated above, at 2 10 A m.

The CAUSE OF DEATH* was as follows:

Anaemia.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date —

Was there an autopsy? No

What test confirmed diagnosis Physical Exam

(Signed) Geo. Preston Maxwell M. D

7/27 1924 (Address) 401 E 25th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	July 26 1924
20-UNDERTAKER.	ADDRESS
Jos Jacobs & Son	2478 Pa Ave

WRITE PLAINLY, with unfading ink. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Wymans Park)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88870

CERTIFICATE OF DEATH.

170 D 88870

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Wymans Park St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roger H. Hartzell

(Residence in Baltimore: No. 2326 N. Charles W 20156 Pimlico Road St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March (Month) 21 (Day) 1899 (Year)

7-AGE.	If LESS than 1 day,
25 yrs. 4 mos. 2 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER. George W. Hartzell

11-BIRTHPLACE OF FATHER, (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER. Urelia Beitman

13-BIRTHPLACE OF MOTHER, (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry B. Bender

(Address) Gettysburg Pa.

15-

Filed JUL 24 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound through head Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

July 24 1924 (Address) 3632 Rolandene

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Gettysburg Pa.	July 24 1924

20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

(1)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88871

CERTIFICATE OF DEATH.

90 D 88871

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Argyle ave ST. 17 WARD)

2-FULL NAME Thomas H. Brooks

(a) RESIDENCE No. 1027 Argyle ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Brooks

6 DATE OF BIRTH (month, day, and year) Mar. 4-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 19 Registrar

Robert P. Garrison, Burial Permit Clerk.

L 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 21, 1924.

that I last saw h alive on July 21, 1924

and that death occurred, on the date stated above at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Dld an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayes, M. D.

7/24 1924 (Address) 613 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL July 23 1924

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.—400 Blks.

D 88872

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 88872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 200 N. Ellwood Ave St., b Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dachner

(a) Residence No. 200 N. Ellwood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Dachner

6-DATE OF BIRTH (month, day and year) Dec 25-1860

7-AGE. 63 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Henry Dachner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Caroline Hoffman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Maggie Dachner
(Address) 200 N. Ellwood Ave

15- Filed JUL 24 1924 Robert P. Harrison Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 23-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to July 23 19 24
that I last saw h.. Alive on July 23 19 24
and that death occurred, on the date stated above, at 5.55 P. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

from Unknown
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Graham M. D.
July 23 19 24 (Address) 3100 Hoffman Bldg

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 26 19 24
UNDERTAKER	ADDRESS
Chas F. Ernst & Son	118 W. Mt. Royal Ave

8—WHITE PEOPLE, WHEN ONLY ONE RACE is reported EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88873

CERTIFICATE OF DEATH.

D 88873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Stricker ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. King

(a) RESIDENCE No. 9 S Stricker St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1yr 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer) 064

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Martin F. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Reddington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martin F. King (Address) 9 S. Stricker St

15 Filed JUL 24 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 19 24

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1924, to July 22, 1924, that I last saw her alive on July 22, 1924, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Cortero Sclerosis 1 yr.

Chronic nephritis 1 yr.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 2 mo

Uremia 2 do (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw V Coculman, M. D.

, 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	July 26 19 24
UNDERTAKER Harry N. Witzke	ADDRESS 53 W Lombard St

AGE should be stated EXACTLY. PHYSICIANS should write plainly so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88374

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Pulaski ST., 70 WARD)

2-FULL NAME Mary Corran

(a) RESIDENCE NO. 217 S Pulaski ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Charles James Corran

6 DATE OF BIRTH (month, day, and year): July 26/1840

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Langdon

11 BIRTHPLACE OF FATHER (city or town) (State or country): New England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Corran

(Address): 217 S. Pulaski St

15 JUL 24 1924

Robert P. Harrison, .19 .....
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1924, to July 23, 1924, that I last saw h alive on July 17, 1924, and that death occurred, on the date stated above, at 5 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Age.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edward A Crans, M. D.

. 19 (Address) 101 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: July 26 1924

20 UNDERTAKER: Harry A. Witzke

ADDRESS: 153 W. Lombard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

88875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88875

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Boucher

(a) Residence No. Mt Hope Retreat St., 28th Ward Annapolis, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Feb 17-1860

7-AGE, 64 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Brick Mason

(c) Name of employer Annapolis

9-BIRTHPLACE (city or town) Md

(State or Country),

PARENTS.

10-NAME OF FATHER Joseph Boucher

11-BIRTHPLACE OF FATHER (city or town) Phila

(State or Country), Pa

12-MAIDEN NAME OF MOTHER Catherine (?)

13-BIRTHPLACE OF MOTHER (city or town) Annapolis

(State or Country), Md

14- (Informant) Records of Mt Hope Retreat

(Address) Baltimore Md

15- Robert F. Harrison,

Filed ....., 192.... Registrar.

Burial Permit Clerk.

JUL 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 9th, 1924, to July 24, 1924, that I last saw h.. alive on July 24, 1924, and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Paralysis Post Cerebral

arteriosclerosis

Obl (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Mania Psychosis

Obl (Duration) yrs. 2 mos. 0 ds.

18-Where was disease contracted if not at place of death? Annapolis Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Annapolis Md — DATE OF BURIAL, July 24 1924

20-UNDERTAKER Jas S. Taylor Sons — ADDRESS Annapolis Md

IMPORTANT—PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Names should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88876

CERTIFICATE OF DEATH.

164

D 88876

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 W. 42nd. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Thomas

(a) Residence No. 1311 W. 42nd. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 70 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Thomas

6-DATE OF BIRTH (month, day and year) April ? 1840

7-AGE. 84 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, John Irwin

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Ireland

14- (Informant) Emily G. Thomas

(Address) 1311 W. 42nd. St.

JUL 25 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 22 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24 to July 22 19 24

that I last saw h.. alive on July 22 19 24

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Indefinite (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ...yrs. ...mos. 2 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? General Condition

(Signed) R. B. Norment M. D

7/25 19 24 (Address) 354 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	7/25 1924
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88877

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Malone

(a) RESIDENCE NO. 6787 W. Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Malone

6 DATE OF BIRTH (month, day, and year) About 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall, Md.

PARENTS

10 NAME OF FATHER ? Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm. H. Malone
(Address) 6787 W. Balto. St.

15 Filed JUL 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Self induced abortion)

(duration) yrs. mos. ds.

(Signed) D. L. E. Hennessy M. D.
(Coroner.)

July 24 1924 (Address) 2812 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	7/25/24
20 UNDERTAKER	ADDRESS
Leo J. Smith	1532 Hollins St

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

ec—12-23-21—E.B.R.S.—400 Bks.

D 88878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 88878

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 W. Hamburg St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Knodt

(a) Residence No. 701 W. Hamburg St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) July 1, 1901

7-AGE, ... yrs. ..... mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Louis Knodt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary Wagner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Louis Knodt

(Address) 701 W. Hamburg St.

15- Filed JUL 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24 24

17- I HEREBY CERTIFY, That I attended deceased from July 17, 19 24, to July 24, 19 24, that I last saw h[illegible] alive on July 23, 19 24, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Colitis

(Duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. M. Hellerstein M. D.

, 19 (Address) 2733 N. Charles Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park. DATE OF BURIAL, July 25, 19 24

20-UNDERTAKER, Wm. H. Reisle & Son ADDRESS 801 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&H 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38879

CERTIFICATE OF DEATH.

161-001 D 38879

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Covington ST., 24 WARD)

2-FULL NAME Unnamed, (Infant Moler)

(a) RESIDENCE NO. 547 Covington ST., 24 WARD.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7/12 Fetal	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Earle Franklin Moler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Gladys Rue Lowry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Earl Franklin Moler

(Address) 547 Covington St.

15 JUL 25 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from 7.24, 1924, to 7.24, 1924, that I last saw him alive on 7.24, 1924, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth,
Lived 3 & 3/4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Praevia (duration) 7 months

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. F. Purlington, M. D.

, 19 (Address) 1028 Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	7/25/1924
20 UNDERTAKER	ADDRESS
E. P. Fanning & Son - 1460	Battery ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88880

CERTIFICATE OF DEATH.

31 D 88880

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Retreat St ST., 13 WARD)

2-FULL NAME Lawrence Ambrose Rhodes

(a) RESIDENCE No. 1412 Retreat St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 9 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	34	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker ?

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert H. Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan C. Calahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Robert H. Rhodes
(Address) 1412 Retreat St.

15 Filed JUL 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from June ..., 1924, to July 24th, 1924.

that I last saw him alive on July 23rd, 1924.

and that death occurred, on the date stated above, at 2.00 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis,

(duration) 1 to. 7 yrs mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Tuber. Bac. in sput

(Signed) A. M. Hoffman M. D.

(Address) 7/24 1924 2402 Wallbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 26, 1924
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 N. Howard Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 88881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88881

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glenmore Hotel ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard L. Stonnell

(a) RESIDENCE No. 2205 N. Balto St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Stonnell

6 DATE OF BIRTH (month, day, and year) Feb 26-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	56	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit & Produce

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robt T Stonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Ruth Stonnell

(Address) 2205 N. Baltimore St

15 Filed JUL 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 3. 1924, to July 23 1924.

that I last saw him alive on July 23 1924

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Myocardial insufficiency

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D Aschenbrat M. D.

7-24 1924 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood Cem. Washington D.C.	July 26 1924

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North Pa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 88882

1-PLACE OF DEATH D 88882

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Lemmon Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lorenzo

(a) RESIDENCE NO. 735 W. Lombard St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Lorenzo Lorenzo

11 BIRTHPLACE OF FATHER (city or town) Foreign
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Virgie Marie Ryan

13 BIRTHPLACE OF MOTHER (city or town) Christiana
(State or country) Maryland

14 ... (Informant)
(Address) ... JOHNS

15 ... (Undertaker)

JUL 25 1924

JUL 25 1924 ROBERT R. KRAUTER, Registrar

1683 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924.

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to July 23, 1924, that I last saw h... alive on July 23, 1924, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital weakness

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY .....
(Secondary)

.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Bernard J. Tenny, M. D.

7/24 1924 (Address) 915 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL 3111

DATE OF BURIAL 24 1924

20 UNDERTAKER Commissioner Health,

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 28

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88883

CERTIFICATE OF DEATH.

7-18-003

D 88883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen. Hosp. St., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Cloney

(a) RESIDENCE No. Colgate Rd, Catonsville Md. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Cloney.

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Deeds. 166
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John T. Cloney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cathryn Dougal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Mrs. M. Cloney
(Address) Colgate Rd Balto. Co. Md.

15 Filed JUL 25 1924, 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

15 min.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably struck by an automobile

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

(Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 26 192 4
20 UNDERTAKER John J. Fields	ADDRESS 1200 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 88884

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 22 E. Lanvale St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John E. Mitchell

(a) Residence No. #713 N. Belnord Ave. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie E. Mitchell

6-DATE OF BIRTH (month, day and year) Dec. 4th. 1860

7-AGE. 64 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.. American Bank

9-BIRTHPLACE (city or town)..... (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Mitchell

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sadie E.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

11-

(Informant).. Howard H. Mitchell

(Address).... #713 N. Belnord Ave.

15-

Filed ..... 19 ROBERT R. KRAUTER,

JUL 25 1924 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 22nd. 24

I HEREBY CERTIFY, That I attended deceased from May 2 24 to July 22 24 19.....

that I last saw ... alive on July 20 19 24

and that death occurred, on the date stated above, at 10.15 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Neck 2 yrs

CONTRIBUTORY (Secondary) Edema

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? No extraction 7 months

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

July 24 19 24 (Signed) E. E. Slade M. D

(Address) 1436 Bond

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	7/25 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88385

CERTIFICATE OF DEATH. 74-002

D 88385

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Fillen

(a) RESIDENCE. No. 2410 Stockton ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Millington, Md

PARENTS

10 NAME OF FATHER John Fillen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed JUL 25 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-21 1924 to 7-22 1924 that I last saw him alive on 7-22 1924 and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Thrombosis (Left Hemiplegia)

(duration) yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Dixon, M. D.

7-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 26 1924
20 UNDERTAKER	ADDRESS
Mrs Jas N. Dennis	1303 Freestman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 88886 HEALTH DEPARTMENT—CITY OF BALTIMORE

114 D 88886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 White St. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Morris

(a) RESIDENCE NO. 1812 White St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Morris

6 DATE OF BIRTH (month, day, and year) about 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Canning factory
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Julius Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary P.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Margaret Joyce
(Address) 1518 Myrtle ave.

JUL 25 1924

15 July 25, 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jur (Inquest, autopsy or inquiry.) find that said deceased came to Hus death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Acute gastro-Enteritis

(duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart 5 minutes

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

July 23, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Water View Middlesex Co. Va	July 25 1924
20 UNDERTAKER Mrs James H. Dennis	ADDRESS 1303 Freestman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 88887 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88887

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 1512 Madison Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Dugdale Miller

(a) Residence No. 1512 Madison Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Miller

6-DATE OF BIRTH (month, day and year) Nov 3/1861

7-AGE. 67 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm A Dugdale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Eleanor Graham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Howard A Dugdale

(Address) 1512 Madison ave

15- JUL 25 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 24/1924

17- I HEREBY CERTIFY, That I attended deceased from July 20 1924 to July 24 1924, that I last saw h[illegible] alive on July 23 1924, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Urine Blood Exam

(Signed) A H Ingram M. D.

, 19 (Address) 2429 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL, July 26 1924

20-UNDERTAKER Harry H Annacost — ADDRESS 4204 Ridgewood Ave

N. B.—WHITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. should be carefully supplied. AGE should be stated E. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 88888 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88888

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE, (No. 4030 Belle Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leoline Edith Harn

(Residence in Baltimore: No. 4030 Belle Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 27, 1841 (Month) (Day) (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Evans

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willard Harn

(Address) 2506 N. Calvert

15- Filed JUL 25 1924, 191.... Hall Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to July 23 1924, that I saw h[illegible] alive on July 23 1924, and that death occurred, on the date stated above, at 11.55P m.

The CAUSE OF DEATH* was as follows:

1 Hydronephroma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. T. Lucas M. D.

7/24, 1924 (Address) 3501 Gwynn Oak

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem DATE OF BURIAL, July 26, 1924

20-UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 38889 HEALTH DEPARTMENT—CITY OF BALTIMORE D 38889

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Fremont ave. WARD) 7

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Wood.

(a) RESIDENCE. No. 801 Fremont ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Jacob Ewen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Luther Wood

(Address) 801 N. Fremont Ave

JUL 25 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24. 1924

17

I HEREBY CERTIFY, That I attended deceased from April 10- 1924, to July 24- 1924

that I last saw her alive on July 23- 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,
Arterio Sclerosis.

(duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Uremia -

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) J. Bond Spencer, M. D.

, 19 (Address) 2128 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cem	July 28 1924

20 UNDERTAKER Chas. E. Franck

ADDRESS 202 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-0 D 88890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 W. Lexington ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Davis Hallman

(a) RESIDENCE No. 1031 W. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James R. Hallman

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Va

PARENTS

10 NAME OF FATHER Jack Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Va

12 MAIDEN NAME OF MOTHER Elizabeth Dowdy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Va

14 Informant James R. Hallman

(Address) 1031 W. Lexington

15 JUL 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1 1924, to July 23 1924, that I last saw h-r alive on July 23 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

ulcer of Duodenum

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) perforation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stomach Contents

(Signed) ..... M. D.

7-24, 1924 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hancock Va

DATE OF BURIAL July 26 1924

20 UNDERTAKER Samuel T. Handy

ADDRESS W. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88891

D 88891

128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Moore ST., 17th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmanuel Charles Williams

(a) RESIDENCE NO. 523 Moore ST., 17th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie Williams

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer ?

9 BIRTHPLACE (city or town) Rock Hill (State or country) S. C.

PARENTS

10 NAME OF FATHER Jona Williams

11 BIRTHPLACE OF FATHER (city or town) Rock Hill (State or country) S. C.

12 MAIDEN NAME OF MOTHER Susan Steele

13 BIRTHPLACE OF MOTHER (city or town) Rock Hill (State or country) S. C.

14 Informant Marie Williams (Address) 523 Moore

Filed JUL 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to July 24, 1924, that I last saw him alive on July 23, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis.

(Signed) Wilbur T. Roy Barnes, M. D.

, 19 (Address) 1319 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL July 1924

20 UNDERTAKER Samuel T. Hensley ADDRESS 3[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Horton . Curtis . Cause

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88892

CERTIFICATE OF DEATH.

D 88892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 South Stricker ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie M Smith

(a) RESIDENCE NO 341 South Stricker ST., ... WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J Smith

6 DATE OF BIRTH (month, day, and year) Sept 6. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Petersburg. Va

PARENTS

10 NAME OF FATHER John W. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant William J Smith
(Address) Petersburg, Va

15 JUL 25 1924 RUBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno B. Horton, M. D.

July 25 1924 (Address) Curtis Bay (County.) Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds. Md

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg. Va

DATE OF BURIAL July 25 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Hoch Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88893

CERTIFICATE OF DEATH.

101-69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 Annely ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelly H. Wright

(a) RESIDENCE. No. 227 Annely ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James H. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James Wright

(Address) 227 Annely St

15 JUL 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1924, to July 23, 1924, that I last saw h— alive on July 23, 1924 and that death occurred, on the date stated above, at 6 P, m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

(duration) yrs. 7 mos. 14 ds.

CONTRIBUTORY (Secondary) (a) Stomach

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. H. Hoover, M. D.

July 24 1924 (Address) 712 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL 7/25/24

20 UNDERTAKER R C Grant — ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88894 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 88894

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 328 W. Hoffman St., 11 WARD)

2-FULL NAME Vinia Kitts

(a) RESIDENCE No. 328 W. Hoffman St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nubsman.

6 DATE OF BIRTH (month, day, and year) About 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Nubsman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rosie Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Ida Brown
(Address) 2442 Druid Hill Ave

15 Filed JUL 25 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Dr. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

July 25, 1924 (Address) 28 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 25 1924
20 UNDERTAKER	ADDRESS
Robt. Wellham	1513 McCulloch St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88895

CERTIFICATE OF DEATH.

D 88895

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Susan E Liddell

(a) Residence No. Home for the Aged of the M. E. Church St., Ward.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 9 1844

7-AGE. 80 yrs. 2 mos. 16 ds. If LESS than 1 day, hrs. or mnts.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John Bombergen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ga

12-MAIDEN NAME OF MOTHER. Susan Londonslager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14 (Informant) Ella Cuckely

(Address) 400 N Fulton Ave

JUL 25 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 25/24

17- I HEREBY CERTIFY, That I attended deceased from March 4 1924 to July 25 1924 that I last saw her alive on July 23 1924 and that death occurred, on the date stated above, at 9.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver —

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion and Insanition

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C Shannon M. D

7/25 1924 (Address) 700 Fulton Ave —

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westminster

DATE OF BURIAL. 7/26/24

20-UNDERTAKER. Geo J Smith

ADDRESS 1532 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88896

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 George ST.: 17 WARD)

2-FULL NAME Sarah Brown

(a) RESIDENCE. No. 644 George ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1st 1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Olivia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Anetta Williams

(Address) 644 George St

15 Filed JUL 25 1924 . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8— , 1924, to July 24, 1924

that I last saw h[illegible] alive on July 23— , 1924

and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Artura Sclerosis

about (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Examination

(Signed) Samuel A Bauer, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	July 26 1924
20 UNDERTAKER Mrs. R.G. Elliott	ADDRESS 725 Madison

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88897

CERTIFICATE OF DEATH.

75-001 ✓

D 38897

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Druid Hill St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tyler Olivers

(a) RESIDENCE. NO. 1311 Druid Hill ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Olivers

6 DATE OF BIRTH (month, day, and year): Aug - 1838

7 AGE — Years: 85 — Months: 11 — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Gloucester Co Va

PARENTS

10 NAME OF FATHER: Harry Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Gloucester Co Va

12 MAIDEN NAME OF MOTHER: Mary Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gloucester Co Va

14 Informant: Fannie Hamm Parker

(Address): 1414 Druid Hill ave

15 JUL 25 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to July 24, 1924, that I last saw her alive on July 23, 1924, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2109 Division St

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical

(Signed) Wilbur H. Wright, M. D.

19 24 (Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: 7-27-24

20 UNDERTAKER: Jno. M. Johnson — ADDRESS 1509 Druid Hill Ave

N. B.—WHILE PLEASE, WRITE PLAINLY WITH INK. DO NOT USE PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88898 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88898.

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3506 Railroad ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther E. Biggs

(a) Residence No. 3506 Railroad ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femal

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William D Biggs

6-DATE OF BIRTH (month, day and year) April 20, 1870.

7-AGE. 54 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, John Hare

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country).

12-MAIDEN NAME OF MOTHER, Mary Bull

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country).

14-(Informant) William D. Biggs

(Address) 3506 Railroad Ave.

15-Filed JUL 25 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 24th July 1924

17-I HEREBY CERTIFY, That I attended deceased from Jan 1st 19 24 to July 24 19 24

that I last saw h.. alive on July 23rd 19 24

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical findings

(Signed) P. S. Gilbert M. D.

July 24 19 24 (Address) 1509 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. July 26 1924

20-UNDERTAKER. CHENOWETH & SON

ADDRESS 317 CHESTNUT AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88899

CERTIFICATE OF DEATH.

8

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2243 Mura ST.; 8 WARD)

2-FULL NAME Wm E. Woods

(a) RESIDENCE. No. 2243 Mura ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 28/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Elroy Woods

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Christina Wade

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mr Elroy Woods
(Address) 2243 Mura St.

15 Filed ....., 19 .....
Registrar

JL 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to July 25, 1924, that I last saw h alive on July 25, 1924, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. L. Campbell, M. D.

July 25, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	July 26 1924

20 UNDERTAKER Jas T Lewis, ADDRESS 1434 E Balto

INSTRUCTIONS.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88900 ✓ D 88900

CERTIFICATE OF DEATH.

74 002

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minot Barrett

(a) RESIDENCE NO. 13 W. Balt. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Minot Barrett

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Babcock

13 BIRTHPLACE OF MOTHER (city or town) Phila (State or country) Pa

14 Informant Hospital Record.
(Address)

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/24

17 I HEREBY CERTIFY, That I attended deceased from 6/25/24, 19..... to 7/25/24.

that I last saw h— alive on 7/25/24

and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ground

(Signed) K. W. Hedley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 28 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 25 1924

Spec.—1-10-21—M&T—1500 Bks.

D 88901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88901

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. John F. Pennington

(a) RESIDENCE NO. 1826 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche B. Pennington

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	81	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work medical doctor

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Pennington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Pryor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Blanche B. Pennington (Address) 1826 Bolton St

15 Filed JUL 25 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to July 24, 1924, that I last saw him alive on July 24, 1924, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic duodenal ulcer

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Gall stones; jaundice (duration) yrs. 4 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Vomitus + stool.

(Signed) Ray Martin, M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: July 26 1924

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W. Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Gallagher)

D 88902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88902

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 W Hamburg ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gallagher

(a) RESIDENCE NO 758 W Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 2-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant John Gallagher
(Address) 622 Eutaw St. Westport

15 Filed ....., 192 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or Inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. 4 mos. hours

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) T H Gorsuch, M. D.
(Coroner.)

7, 25, 1924 (Address) 110 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross G. G. Co

DATE OF BURIAL 7-28 1924

20 UNDERTAKER James A Bryson & Son

ADDRESS 1000 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88903

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1345 Ramsay ST. 19 WARD)

2-FULL NAME Louis Gugliett

(a) RESIDENCE. No. 1345 Ramsay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Gugliett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Mary O'Dea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Mary Gugliett
(Address) 1345 Ramsay St.

15 Filed JUL 25 1924 19 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 24

17 I HEREBY CERTIFY, That I attended deceased from July 23, 19 24, to July 24, 19 24, that I last saw him alive on July 23, 19 24, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness, M. D.

19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd	7-26 19 24
20 UNDERTAKER	ADDRESS
Thomas Dignan Sons	[illegible]

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88904

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 S Ellwood Ave St. 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Laura G. Filbert

(a) Residence No. 6 S Ellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura M Filbert

6-DATE OF BIRTH (month, day and year): July 6 1879

7-AGE: 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer: Manner Baker Works

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Bernard Filbert

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Caroline Grundauer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Laura M Filbert

(Address): 6 S Ellwood Ave

15-

Filed: Robert P. Harrison, Registrar.

JUL 25 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 24/24

17- I HEREBY CERTIFY, That I attended deceased from Jany 1924 to July 24 1924, that I last saw h.. alive on July 24 1924, and that death occurred, on the date stated above, 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Tubal Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Lore, M. D.

7/25, 1924 (Address) 701 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem'y	July 26, 1924
20-UNDERTAKER.	ADDRESS
William Cahill & Bro.	E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88905

CERTIFICATE OF DEATH.

D 88905

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Leadenhall ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Taylor

(a) RESIDENCE NO. 813 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Taylor.

6 DATE OF BIRTH (month, day, and year) —— 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 86

(b) General nature of Industry, business, or establishment in which employed (or employer) on Steamboats

(c) Name of employer + Stationary -

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Phillip Taylor

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Cogbill

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Sadie Taylor
(Address) 813 Leadenhall

JUL 26 1924

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 1924

17

I HEREBY CERTIFY, That I attended deceased from 4/14, 1924, to 7/24, 1924, that I last saw h— alive on 7/23, 1924, and that death occurred, on the date stated above, at 4 a, m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis +
myocarditis -

(duration) yrs mos ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) Dav Frankin M. D.

7/24, 1924 (Address) 172 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL July 26, 1924

20 UNDERTAKER John H. Foadem — ADDRESS 142 W Lee St

N.B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88906

CERTIFICATE OF DEATH.

1924 D 88906

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Promounce dead at

2-FULL NAME Francesco Barbarino

(a) RESIDENCE NO 398 Forrest St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Giovamina Vispico

6 DATE OF BIRTH (month, day, and year) Jan 15/ 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery Store &
(b) General nature of industry, business, or establishment in which employed (or employer) Ice Dealer
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Filippo Barbarino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giovamina Scarlata

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Bernardo Alamio
(Address) 401 Forrest St

15 Date rec'd 1924 Robert P. Harrison, Registrar

JUL 26 1924

Burial Permit Clerk!

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound thru both ventricles of heart-Homicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patton, M. D.
(Coroner)

7/25/24 192 (Address) 705 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent's Cem DATE OF BURIAL 7/30/24 192

20 UNDERTAKER Geo. J. Peth ADDRESS 1705 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 38907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38907

CERTIFICATE OF DEATH.

3N

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1823 N Durham St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Florence M. Keenan

(a) Residence No. 1823 N. Durham st. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James Keenan

6-DATE OF BIRTH (month, day and year) Feb 22/1896

7-AGE. 28 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Edward M. Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Florence V. Bair

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14-(Informant)..... James Keenan

(Address) 1823 N. Durham

15-Filed JUL 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24/24

17- I HEREBY CERTIFY, That I attended deceased from July 1 19 24 to July 24 19 24 that I last saw h~~e~~ alive on July 23 19 24 and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? X-ray

(Signed) Alan B. Lemmon M. D

7/25, 19 24 (Address) 718 N Calhoun St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery. DATE OF BURIAL. July 26 1924

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Hayford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52 D 88908

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

2-FULL NAME William L. Browning

(a) RESIDENCE NO. 218 Hanford Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 2/14/1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

7-26 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1924, to 7-22, 1924

that I last saw him alive on 7-21, 1924

and that death occurred, on the date stated above, at 2.25 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Chronic Impaction

Arthritis Hypertrophic

(duration) yrs. mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ante

(Signed) Claude E. Brace, M. D.

7-22, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 26 1924

20 UNDERTAKER ADDRESS

George J. Ruth 1735 Hanford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... s on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 88909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-00D 88909

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1603 Aisquith St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry W. Heinz

(a) Residence No. 1603 Aisquith St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Heinz

6-DATE OF BIRTH (month, day and year) Dec. 22 1849

7-AGE. 74 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Later

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER, Henry Heinz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Anna Heinz

(Address) 1603 Aisquith St

15- Robert P. Harrison, M.D. 192.....

Registrar.

JUL 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 23/24

17- I HEREBY CERTIFY, That I attended deceased from July 9 1924 to July 23 1924

That I last saw h alive on July 20 1924

and that death occurred, on the date stated above, at 2.00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ....yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 7 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) John W. Jandrow M. D.

, 19 (Address) 1714 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. July 26 1924

20-UNDERTAKER. Geo. J. Ruth — ADDRESS 1735 Harford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Patapsco St. Brooklyn. ST., 15 WARD)

REGISTERED NO. 74-99

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara V. Meredith.

(a) RESIDENCE NO. 1808 N. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of— (or) WIFE of George Meredith.

6 DATE OF BIRTH (month, day, and year) November 27, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Dennis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah E. Plummer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Stella Meredith. (daughter).
(Address) 1808 N. Fulton Ave.

15 Filed JUL 26 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 25, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL JULY 26 1924

20 UNDERTAKER John F Dennis — ADDRESS 715 Light St.

Spec—12-23-21—E.B.R.S.—400 Bks.

Hammondtree Hamilton & St. St.

D 88911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88911

164

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 902 S. Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Eliza Starling.

(a) Residence No. 902 S. Hanover St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Sidney

6-DATE OF BIRTH (month, day and year) April 10 83

7-AGE. 90 yrs. 3 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). England

PARENTS.

10-NAME OF FATHER. William Ward

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Louise Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Mrs. Emily Kurtz

(Address) 902 S. Hanover

15- Filed ..... 192.... Robert P. Harrison, Registrar.

JUL 26 1924 (Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to July 26 19 24

that I last saw h.. alive on July 26 19 24

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Senile debility

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Hammonbach M. D

July 26, 1924 (Address) 4 E. Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Christ Cem. DATE OF BURIAL, July 28 1924

20-UNDERTAKER. Wm. Cook ADDRESS 1121 E. Pratt

WHITE CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88912

CERTIFICATE OF DEATH.

D 88912

1924

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Gross.

(a) RESIDENCE NO 917 N. Central Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) March 2, 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Trucker.

(c) Name of employer

$6

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Emanuel Gross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary King.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Emanuel Gross (brother).

(Address) 1933 Christian Street.

15 Date JUL 26 1924 Registrar Robert P. Harrison

Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in heart & lung
Fired by detectives in discharge
of duty and in self defense.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 25. 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? On lot 800 Block Calvert St. July 23, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 7-26 1924

20 UNDERTAKER Wm J. Cowan & Son ADDRESS 701 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88913

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Guilford Av. ~~St.~~ | 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fletcher Fenby

(a) RESIDENCE. No. 1711 Guilford Av. ~~St.~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 31 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable foreman 886

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Amer. Ry. Express Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER William Fenby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Edwin B. Fenby

(Address) 1223 N. Caroline St.

15 Filed JUL 26 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 — 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 9 — 1924 to July 25 — 1924

that I last saw him alive on " " 1924

and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease - Mitral

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

7/25/1924 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	7/28 1924

20 UNDERTAKER Wm Gott

ADDRESS 502 E. Nort...

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88914

Registered No. 2345

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 Grantley St., 16 Ward) 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... William Edward Smith

(a) Residence No. 608 Grantley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Mary L. Yeatman

6-DATE OF BIRTH (month, day and year) July 19, 1892

7-AGE. 32 yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electric Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

(c) Name of employer Bethlehem Steel Co.

9-BIRTHPLACE (city or town) (State or Country), Brooklyn Anne Arundel Co.

PARENTS.

10-NAME OF FATHER, William L. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Brooklyn Anne Arundel Co.

12-MAIDEN NAME OF MOTHER, Bertie S. Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), White Haven Eastern Shore

14- (Informant) Mrs. Mary L. Smith (Address) 608 Grantley St

15- Filed JUL 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 24/24

17- I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 24, 1924, that I last saw h~~im~~er alive on July 24, 1924, and that death occurred, on the date stated above, at 9 20 m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Unknown. (6 mo ?)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) L. E. Lally M. D.

, 19 (Address) 3500 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Pro Cathedral DATE OF BURIAL, 7/26, 1924

20-UNDERTAKER, Philip Henry ADDRESS 2016 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88915

CERTIFICATE OF DEATH. 185

D 88915

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 N. Smallwood ST., 15 WARD)

2-FULL NAME Anna Reibert

(a) RESIDENCE NO. 1733 N. Smallwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town und State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Reibert

6 DATE OF BIRTH (month, day, and year) Nov 3, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	79	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Puvost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Puvost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest Reibert
(Address) 1733 N. Smallwood St

15 Filed JUL 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 24

17 I HEREBY CERTIFY, That I attended deceased from July 10 , 1924 , to July 24 , 1924 , that I last saw h[illegible] alive on July 23 , 1924 , and that death occurred, on the date stated above, at 9-55 A m.

The CAUSE OF DEATH* was as follows:

(a) Acute Dilat. Heart
Fracture of skull D. S. N.
(duration) ... yrs. ... mos 17 ds.

CONTRIBUTORY (Secondary) Fall down stairs
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Kramer, M. D.

July 25 1924 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL July 26 1924

20 UNDERTAKER Mrs. Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88916

CERTIFICATE OF DEATH.

74-001 D 88916

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 Light ST. 23 WARD)

2-FULL NAME Catherine D. Dunn

(a) RESIDENCE NO. 1432 Light St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Dunn.

6 DATE OF BIRTH (month, day, and year) 6/29/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Ehlers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Susan Clift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Miss Lulu Dunn (Address) 1432 Light St

15 ..... 19..... Registrar

Robert P. Harrison, Burial Permit Clerk.

OL 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 24

17 I HEREBY CERTIFY, That I attended deceased from July 18, 19 24, to July 24 19 24.

that I last saw h.. alive on July 20, 19 24

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 4 ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Bruns, M. D.

July 26, 19 24 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. — DATE OF BURIAL 7/26/24

20 UNDERTAKER Jno J. Fahey & Sons — ADDRESS 1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXACT information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 3543 88917

16-002 D 88917

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST. 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE No. 106 W Lee St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 31, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Donald Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margarette Bonner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924. to July 25, 1924.

that I last saw him alive on July 25, 1924.

and that death occurred, on the date stated above, at 5 12 A. m.

The CAUSE OF DEATH* was as follows: Tumor (Medulloblastoma)

Dysentery (Bacillary).

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Chas. R. Bagg, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Ass'n. Rd. DATE OF BURIAL July 26 1924

20 UNDERTAKER F. G. Hauer & Son ADDRESS 1039 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88918

CERTIFICATE OF DEATH.

D 88918

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Dukeland St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Covell

(a) Residence No. 1007 Dukeland St., 16 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joel C. F. Covell Sr

6-DATE OF BIRTH (month, day and year) June 30 1857

7-AGE. 67 yrs. — mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John F. Mohr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sofia Ubert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). U. S.

11- (Informant) Mr. Joel C. F. Covell Sr.

(Address) 1007 Dukeland st

13- (Date) July 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 16 1924 to July 24 1924

That I last saw h.r alive on July 24 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cebreral Hemorrhage

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Delcher M. D.

July 26 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	July 28. 1924
20-UNDERTAKER.	ADDRESS
Jos Joerdens & Son	217 S. Paca st

JUL 26 1924

Spec—12-23-21—E.B.R.S.—400 Bks. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88919

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 N. Gilmore ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Anderson

(a) RESIDENCE NO. 1309 N. Gilmore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced (write the word)~~
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-26-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Box factory)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Calvert Co., Md.

PARENTS

10 NAME OF FATHER James T. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co., Md

14 Informant Mary Titus.
(Address) 1307 N. Gilmor St

15 JUL 26 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-1- 1924, to 7-25- 1924, that I last saw h alive on 7-23- 1924, and that death occurred, on the date stated above, at 2.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Probably (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

1-25 1924 (Address) 1320 N. Mobert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooks Chapel Calvert Co	July 27 1924
20 UNDERTAKER	ADDRESS
Wm. H. Chase Son	1000 Mosher

WHITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD. PHYSICIANS ... State
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... Exact statemen
CAUSE OF DEATH in plain terms, so that it may be properly classified. ... OCCU
TION is very important. See instructions on back of certificates. ... certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88920

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 88920

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Chester ST., V WARD)

2-FULL NAME Clara Kowalski

(a) RESIDENCE NO. 414 S. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-16-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Kowalski.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Scresik.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore. (State or country) Md.

14 Informant Frank Kowalski. (Address) 414 S. Chester St

15 JUL 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to July 26, 1924, that I last saw her alive on July 25th, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 27-1924.
20 UNDERTAKER	ADDRESS
M. J. Sadowski.	705 S. Ann

A—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. PHYSICIAN ... should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8892F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8921

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2017 E Chase St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward R Mc Dowell

(a) Residence No. 2017 E. Chase St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anna M Mc Dowell

6-DATE OF BIRTH (month, day and year) Sept 3-1864

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER John Mc Dowell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ire

12-MAIDEN NAME OF MOTHER Elizabeth Heigel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Gowson Md

14- (Informant) Anna M. Mc Dowell

(Address) 2017 E Chase St

15- Filed JUL 26 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23-1924

17- I HEREBY CERTIFY, That I attended deceased from July 1- 1924, to July 23. 1924 that I last saw h... alive on July 23. 1924 and that death occurred, on the date stated above, at 1 [illegible] m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward R. Mc Dowell M. D.

7-24, 19.. (Address) 2017 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, July 26, 1924

20-UNDERTAKER Robt J. Turner Son ADDRESS 1942 N. Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88922

CERTIFICATE OF DEATH.

D 88922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hettie Campbell. (C).

(a) RESIDENCE No St Indico ST. St. Marys Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Theodore Campbell. (C).

6 DATE OF BIRTH (month, day, and year) May, 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	2	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER John H. Bennett. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eliza Bennett. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Annie Johnson. (C).
(Address) St. Indico. St. Marys Co. Md.

15 Filed JUL 26 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.

July 25, 1924 (Address) 1011 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? St Indico. St. Marys Co. Md.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Wlf. St. Marys Co. Md. DATE OF BURIAL 7/26 1924

20 UNDERTAKER Raul Earley ADDRESS Pa

IMPORTANT—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88923

CERTIFICATE OF DEATH.

90 D 88923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 N. Mount St. ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Addison

(a) RESIDENCE No. 1521 N. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Addison

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Moses Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Towne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Carter
(Address) 1521 Mount St

15 Filed JUL 26 1924, 192 Robert J. Harrison,
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) senile debility

(duration) yrs. mos. ds.

(Signed) J. C. O. Hennessy, M. D.
(Coroner.)

July 25, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL July 26 192 4

UNDERTAKER Samuel Hennessy ADDRESS 28

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 88924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88924

CERTIFICATE OF DEATH.

3 58 001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., Ward A Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Ryan

(a) Residence No. 1415 Eastern ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, William Ryan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Welch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant)

(Address)

15- Filed ..... 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/23/24

17- I HEREBY CERTIFY, That I attended deceased from ....., 19.. to 7/23, 19.24

that I last saw h. alive on 7/23, 19.24

and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Abscess in L. Popliteal Space

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobaris

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Note

(Signed) Wm. J. Fallon, M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER. ADDRESS

IMPORTANT: Every item must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

612 6 1924 Burial Permit 1634

JUL 26 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88925

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Brooks

(a) Residence No. 2310 Essex st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6-DATE OF BIRTH (month, day and year) 1850

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Missouri

PARENTS.

10-NAME OF FATHER, William H. Brooks

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Annie ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed 192 Registrar.

U 2 6 1924

1635

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 30, 1924 to July 24, 1924

that I last saw him alive on July 24, 1924

and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) J. T. White M. D.

7-24-1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, 19....

20-UNDERTAKER. Commissioner Health, ADDRESS JUL 26 1924

Per Wm. F. Driscoll, Asst. Clerk.

N. B.—WRITE PLAINLY, with pen and ink. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88926

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D 38926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital // St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Davis

(a) Residence No. 16 W. Biddle st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1896

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Samuel Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Georgia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21 19 24 to July 22 19 24

that I last saw h. im alive on July 22 19 24

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Acute myocardial insufficiency (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. F. White M. D.

7-22- 19 24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, 19

20-UNDERTAKER, ADDRESS

Robert F. Garrison

JUL 26 1924

JUL 26 1924

1636

UNIVERSITY OF MARYLAND

IMPORTANT—Should be completed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. NAME should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

(Neal or Geo Shaw)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88927 ✓ D 88927

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 N Wolfe ST., 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neal or Geo Shaw

(a) RESIDENCE NO. 1030 N Wolfe ST. 7 WARD 7 Wood

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Shaw

6 DATE OF BIRTH (month, day, and year) July 15 1877

7 AGE: Years 47; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blades Smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 106

9 BIRTHPLACE (city or town) (State or country) V. C.

PARENTS

10 NAME OF FATHER Fred Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) V. C.

12 MAIDEN NAME OF MOTHER Anderson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington.

14 Informant Maggie Shaw (Address) 1038 N. Wolfe St.

15 Filed JUL 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to July 25, 1924, that I last saw h[illegible] alive on July 26, 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Laceration due to abscess in Hip joint

(duration) — yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J. Emmes, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fayette Ville V. C. — DATE OF BURIAL: July 27, 1924

UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88928

D 88928

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Christs Institution Hospital

City of BALTIMORE: (No. 704 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Young

(a) Residence No. Trappe Md. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Sngl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1909

7-AGE. 15 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Trappe Md.

PARENTS.

10-NAME OF FATHER. Robert Young

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Trappe Md

12-MAIDEN NAME OF MOTHER. Josephine Collins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Trappe Md

14- (Informant) Josephine Collins

(Address) Trappe Md.

Filed JUL 27 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 25-24

17- I HEREBY CERTIFY, That I attended deceased from June 5 - 1924 to July 25 1924

that I last saw her alive on July 25 - 1924

and that death occurred, on the date stated above, at 9.45P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Peritoneum

(Duration) yrs. 5 mos. 11 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Peritoneum (Duration) yrs. 5 mos. 11 ds.

18-Where was disease contracted if not at place of death? Trappe Md.

Did an operation precede death? no Date of

Was there an autopsy? Health Department

What test confirmed diagnosis?

(Signed) Dr S W Bernard M. D

7-26. 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Trappe Md — DATE OF BURIAL: July 27 1924

20-UNDERTAKER: Mrs. R.G. Elliott — ADDRESS: 13 Cumberland

Filed in duplicate EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 118-002 D 88929

D 88929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Day

(a) RESIDENCE No. Adamstown Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Hubert Bowers
(c) Name of employer Adamstiwn Md.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant A. H. Etchison
(Address) Frederick Md.

15 JUL 27 1924 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inqm iry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-intestinal volvulus

(Operation at hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Fuller (Coroner.), M. D.

7/26/24. 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Point of Rocks Md	July 27 192 4
20 UNDERTAKER Joseph B. Cook	ADDRESS 1004 W. Baltimore St

IMPORTANT—Should be Carefully Supplied. AGE should be given CAREFULLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88930

CERTIFICATE OF DEATH.

90 D 88930

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 W Saratoga ST., 18 WARD)

2-FULL NAME Mamie Owings

(a) RESIDENCE NO. 936 W Saratoga ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Wm. Owings

6 DATE OF BIRTH (month, day, and year) April 26, 1891

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
33	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Bertha Tasker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm Owings

(Address) 936 W Saratoga

15 JUL 27 1924 HUBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to July 24, 1924, that I last saw her alive on July 22, 1924, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(duration) yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. T. Howell, M. D.

(Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	July 27 1924.
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 88931

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1241 Ashland ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Snyder

(a) Residence No. 1241 Ashland ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 7/24

7-AGE. yrs. 6 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Sam Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Anna Steinberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Sam Snyder

(Address) 1241 Ashland ave

15-

Filed JUL 27 1924 192 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26 1924.

17- I HEREBY CERTIFY, That I attended deceased from Jan. 27 1924 to July 26 1924

that I last saw h... alive on July 26 1924

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Goldberg M. D.

7/27/1924 (Address) 2210 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dulaney Hemingway | DATE OF BURIAL. 7/27, 1924

20-UNDERTAKER. Sol Grinson & Bro | ADDRESS 1127 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--1-12-23--M&T--100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88932

CERTIFICATE OF DEATH.

X146 D 88932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah Dearborn

(a) RESIDENCE NO Westminster Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry H. Koontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Baer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. J. Bankard (Address) Westminster Md

15 Filed JUL 27 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Abortion induced by some person unknown to me

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch, M. D.
(Coroner.)

7-26, 1924 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Cem.	7/29 1924
20 UNDERTAKER	ADDRESS
J. J. Bankard & Son	Westminster Md

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 88933

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1915 Wilhelm St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clarence Edward Lowman

(a) Residence No. 1915 Wilhelm 1 St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 16 1920

7-AGE.	If LESS than 1 day,
....yrs. 4 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Clarence E. Lowman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Sadie Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Clarence E. Lowman

(Address) 1915 Wilhelm

15- JUL 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 24 1924 to July 26 1924 that I last saw h[illegible] alive on July 26 1924 and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Incision

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Theo Koleman M. D.

July 28 1924 (Address) 1900 W Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Linden Park Cem	July 28 1924
20-UNDERTAKER,	ADDRESS
Jos Jourdens Son	2073 Pres

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D88934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 D 88934

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Kernan Hospital ST. 17 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hyantha Carter Harris

(Residence in Baltimore: No. 2912 Huntington Ave., Balto. Md. St.; 69 yrs. 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: March (Month) 10 (Day), 1855 (Year)

7 AGE: 69 yrs. 4 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Balto. County, Md

PARENTS

10 NAME OF FATHER: Vincent Standiford

11 BIRTHPLACE OF FATHER (State or country): U.S.

12 MAIDEN NAME OF MOTHER: Hyantha Charity

13 BIRTHPLACE OF MOTHER (State or country): U.S.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella M Wagner

(Address) 2912 Huntington Ave

Filed JUL 27 1924 ROBERT R. KRAUTER, Registrar's Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 25 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12th 1924 to July 25th 1924 that I saw h-er alive on July 23 1924. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cer.)

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Fract. Rt. humerus

(Duration) ..... yrs. 1 mos. 10 ds.

(Signed) J Albert Key M. D.

7-25 1924 (Address) 1515 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Newmarket Balto Co | DATE OF BURIAL: July 27 1924

20 UNDERTAKER: Chenoweth & Son 3615 Chestnut ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88935

CERTIFICATE OF DEATH.

D 88935

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Springdale Ave. WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myer Palmbaum

(a) RESIDENCE No. 3302 Springdale Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sadie H. Palmbaum

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ret. Dry Goods
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Isaac Palmbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Hannah Novembl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hyman Palmbaum
(Address) 3302 Springdale Ave

15 Filed JUL 27 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

July 26, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bals. Hebrew Cem. DATE OF BURIAL 7/27/1924

20 UNDERTAKER David Sondheim ADDRESS 1100 W. Mt. Royal Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88936

CERTIFICATE OF DEATH.

24 113

D 88936

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1429 Cookson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Porter

(a) Residence No. 1429 Cookson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
male.	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 8, 1923

7-AGE. ....yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Francis Porter

11-BIRTHPLACE OF FATHER (city or town) Ireland (State or Country),

12-MAIDEN NAME OF MOTHER, Bertha Hemenij

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

11- (Informant) Anna Hemeny

(Address) 1429 Cookson

15- Filed JUL 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 23 1924 to July 26 1924, that I last saw h[illegible] alive on July 25 1924 and that death occurred, on the date stated above, at 2 45a m.

The CAUSE OF DEATH* was as follows:

Ills Colitis.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos F Sellers M. D

7/26, 1924 (Address) 2878 Hampden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Holy Cross & Co.	July 28
20-UNDERTAKER.	ADDRESS.
Chas. L. Sivins	1501 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—5,B[illegible]S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38937

D 38937

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1508 N. Port St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Leitzer

(a) Residence No. 1508 N. Port St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Veronica

6-DATE OF BIRTH (month, day and year) July 4 1855

7-AGE. 69 yrs. — mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bohemia - Europe

PARENTS.

10-NAME OF FATHER, Charles Leitzer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia - Europe

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia Europe

11- (Informant) Veronica Leitzer

(Address) 1508 N. Port st

19 Filed JUL 2 1924 192 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-25-24

17- I HEREBY CERTIFY, That I attended deceased from 7-20 19 24 to 7-25 19 24

that I last saw h[illegible] alive on 7-25 19 24

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Acute Diffused

Nephritis

(Duration) 4 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Rynd M. D.

7-25 19 24 (Address) 600 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill

DATE OF BURIAL. July 28 1924

20-UNDERTAKER Jerkler Jerkler

ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88938

CERTIFICATE OF DEATH. X 21 D 88938

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 811 Harlem Ave St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willard Harrison Kent

(a) RESIDENCE. NO. 811 Harlem Ave ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Student~~ Student

(b) General nature of industry, business, or establishment in which employed (or employer) Labrer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Kent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Addie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Kent (Address) 811 Harlem Ave

15 Filed JUL 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to July 25th, 1924, that I last saw h~~im~~ alive on July 25, 1924, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Blood Poison (Local)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Infected Wound

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas C Capers, M. D.

(Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Va DATE OF BURIAL July 26 1924

20 UNDERTAKER Samuel H Kennedy ADDRESS 1911 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88939 ✓ 003

CERTIFICATE OF DEATH.

24 107 D 88939

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1513 Light St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Revis

(a) Residence No. 1513 Light St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of G. Revis

6-DATE OF BIRTH (month, day and year) Dec 9-1851

7-AGE. 72 yrs. 7 mos. 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS:
10-NAME OF FATHER, Wm. Revis
11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Mr. James H. Revis
(Address) 1513 Light St.

15- Filed JUL 27 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-25-24

17- I HEREBY CERTIFY, That I attended deceased from 7. 18 1924 to 7. 25 1924
that I last saw h[illegible] alive on 7. 25 1924
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage

(Duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Gen Debility, Aged
(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) F. F. Burlington M. D
, 19 (Address) 102 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: 7/28, 1924

20-UNDERTAKER: J. Fran McCully — ADDRESS: 130 E. Fort

N. B.—WRITE PLAINLY, with ink. Items marked * should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Blks.

D Cathurhouse, 1901 Eutaw Place
Mod ✓ 5627

D 88940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88940

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 154 W. Virginia Ave St., 27 44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William E. Hudson Sr.

(a) Residence No. 154 W. Virginia Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Matilda Hudson

6-DATE OF BIRTH (month, day and year) Sept 5. 1862

7-AGE. 61 yrs. 10 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer) Steam Boiler 086

(c) Name of employer Pub. School Baltimore

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER. John Hudson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER. Emma Cooper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md

14- (Informant) Mrs Gladys Clutchey

(Address) 154 W. Virginia Ave

15- Filed JUL 27 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15th 1924 to July 26 1924

that I last saw h. alive on July 26 1924

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray + Physical diag.

(Signed) E. Fontaine Lane M. D

1/29 1924 (Address) 1900 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet

DATE OF BURIAL. July 29 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Nat

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88941

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A Wilson

(a) Residence No. Belgrade Maine Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. 15 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Me

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sara B.

6-DATE OF BIRTH (month, day and year) Aug 22 1871

7-AGE. 53 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Paint 150

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER. Henry Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Myers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Ernest Wilson

(Address) 2015 N. Fremont

15- Filed JUL 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 11th 1924 to July 26th 1924

that I last saw h.. alive on July 26 1924

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 13 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical manifestations & Laboratory findings

(Signed) Wade E Brown M. D

19 (Address) 1013 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Greenmount Cem. | DATE OF BURIAL. July 28 1924

20-UNDERTAKER. Wm Cook | ADDRESS 502 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See should be carefully supplied. AGE should be properly classified. Exact in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 88942

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 E. Biddle ST.; 8 — WARD)

2-FULL NAME James J. Coan

(a) RESIDENCE. No. 1508 E. Biddle ST., 8 — WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Maria Coan

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Mary Murphy
(Address) 1508 E. Biddle St.

15 Filed JUL 27 1924 19

ROBERT R. KRAUSER, Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 — 1924

17

I HEREBY CERTIFY, That I attended deceased from July 22 — 1924, to July 25 — 1924

that I last saw him alive on July 24 — 1924

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

7/25/1924 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	7/28 1924

20 UNDERTAKER C. D. Evans & Son Inc. ADDRESS 118 N. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88943

CERTIFICATE OF DEATH.

1924 D 88943

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Myrtle Bodensack

(a) RESIDENCE NO. 1831 Eagle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm. Bodensack

6 DATE OF BIRTH (month, day, and year) May 13, 1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Mc Cally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Rose M. Cally

(Address) 1831 Eagle St

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1924

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1924, to July 24, 1924,

that I last saw her alive on July 24, 1924,

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

Puerperal Septicemia

Following self-induced abortion

(Duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(Duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 19, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & clin. signs

(Signed) A C Mannings M. D.

7-25-1924 (Address) Col. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 7-28 1924

20 UNDERTAKER Thos. J. Fields — ADDRESS 1200 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88944

88944

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Geiger

(a) RESIDENCE. No. 822 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Geiger

6 DATE OF BIRTH (month, day, and year) April 23 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records (Address)

15 Filed JUL 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-1924

17 I HEREBY CERTIFY, That I attended deceased from 7-1, 1924 to 7-25, 1924 that I last saw her alive on 7-25, 1924 and that death occurred, on the date stated above, at 7:55 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis
Mitral Stenosis & Insufficiency
Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Bruce, M. D

7-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem., Md.	July 28 1924
20 UNDERTAKER Margaret E. Flynn	ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88945

CERTIFICATE OF DEATH.

D 88945

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 S. Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank . Nowakowski

(a) Residence No. 410 S. Chester St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 4 1924

7-AGE. ....yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank Nowakowski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Anna .Reicher

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country). Md.

14- (Informant). Frank . Nowakowski

(Address) 410 S. Chester Street

15- Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 27/24

17- I HEREBY CERTIFY, That I attended deceased from July 26 19 24 to July 27 19 24 that I last saw h. alive on July 27 19 24 and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(Duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Kyser M. D.

(Address) 180 W. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Stanislaus	July 28 1924

20-UNDERTAKER John A. Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88946

CERTIFICATE OF DEATH. Below 1a 90

D 88946

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12½ Parkwood ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Grafton Webb

(a) RESIDENCE. No. 12½ Parkwood Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State) Texas

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Natchez Mississippi

PARENTS

10 NAME OF FATHER Thomas Grafton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi

12 MAIDEN NAME OF MOTHER Martha Hollon Grafton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mississippi

14 Informant Geo. Georgia Landes

(Address) 12½ Parkwood ave

15 JUL 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1924, to July 27, 1924, that I last saw h[illegible] alive on July 27, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of Coronary artery & general arteriosclerosis

(duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) S. Pellegrino, M. D.

7.27.1924 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Houston Texas

DATE OF BURIAL 7/28/24

20 UNDERTAKER Johannah Landes

ADDRESS 1004 Aisquith st

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88947

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1611 Gough St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sabino Bontempo .....

(a) Residence No. 1611 Gough St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): June 2 1924

7-AGE. ..... yrs. 1 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9-BIRTHPLACE (city or town) (State or Country): Balt

PARENTS.

10-NAME OF FATHER: Sam Bontempo

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Augusta Mark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Richmond Va

14- (Informant) Sam Bontempo

(Address) 1611 Gough

15-

Filed ..... 1924 ..... Registrar.

JUL 28 1924 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 27 1924

17- I HEREBY CERTIFY, That I attended deceased from 7.26. 1924 to 7/27 1924

that I last saw h.. alive on 7/27 1924

and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ... yrs. ... mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Phy. signs

(Signed) L. B. Tillenberg M. D.

7/28 1924 (Address) 1901 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	July 28 1924
20-UNDERTAKER,	ADDRESS
Wendell Wyeth	37 S Ha

N. B.—WRITE PLAINLY, with pen and ink. ALL QUESTIONS must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88948

CERTIFICATE OF DEATH.

74-001

D 88948

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2643 Wilkins Ave St., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hruz

(a) RESIDENCE (Usual place of abode) No. 2643 Wilkins Ave St., WARD

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise A Hruz

6 DATE OF BIRTH (month, day, and year) 7-25-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 910

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer United Elec Light & Ry Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Schleick

(Address) 2643 Wilkins Ave

Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 26, 1924, that I last saw h[illegible] alive on July 26, 1924, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C E Bruton, M. D.

7/27, 1924 (Address) 301 E Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 29 1924
20 UNDERTAKER George L. Schwartz	ADDRESS 201 Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 88949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1850 88949

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Hosp. ST., W WARD)

2-FULL NAME Elizabeth Ann Desperaux

(a) RESIDENCE NO. 208 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Desperaux

6 DATE OF BIRTH (month, day, and year) March 17, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. C. Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotte Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Chas. Desperaux
(Address) 208 N. Fulton Ave

15 Filed JUL 28 1924 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said I (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of left hip (accidental) (Fell down stairs).
(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia
(duration) yrs. mos. 2 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

July 26, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL July 28 1924

20 UNDERTAKER George L. Schwab ADDRESS 1201 Eutaw St.

(I. P. 8. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88950

90 D 88950

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 712 W Boston ST., 21 WARD)

2-FULL NAME Emma C Rice

(a) RESIDENCE NO. 712 W Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse R. Rice

6 DATE OF BIRTH (month, day, and year) Sept 22-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John F. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Jesse R. Rice (Address) 712 W. Barre St

15 JUL 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1924

17 I HEREBY CERTIFY, That I attended deceased from 7/24, 1924, to 7/26, 1924, that I last saw h.. alive on 7/26/24, 19....., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cath Irregularities

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Brain, M. D.

, 19 (Address) 1107 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russ. M.E. Church Cem DATE OF BURIAL July 29 1924

20 UNDERTAKER W. C. Brooks ADDRESS Sparrows Pt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88951

CERTIFICATE OF DEATH.

161-001

D 88951

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S. 5th St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Miller

(Residence in Baltimore: No. 133 S 5th St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH, 7-27-74 (Month) (Day) 1 (Year)

7-AGE, Premature 1 mo 4 yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Catharine Brunck

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Miller

(Address) 133 S. 5th St.

15-
ROBERT R. KRAUTER,
Filed..... 191. JUL 28 1924
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7/27/1924 · 4 hours, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-27-24 191..., to 7-27-24 191..., that I saw h.. alive on 7-27-24 191..., and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) none

..... (Duration).....yrs.....mos.....ds.

(Signed) F. J. Strassman M. D.

....., 1ST. (Address) 729 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Schwartz Cem. DATE OF BURIAL, July 28., 1924

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88952

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 D 88952

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1149 N.Stricker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel A.Foster,

(a) Residence No. 1149 N.Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)
Female	White	Widow

5a-~~If married~~, widowed, or ~~divorced~~ (~~Husband's name in full~~) WIFE of Charles S.Foster,

6-DATE OF BIRTH (month, day and year) July 1.1862

7-AGE.	If LESS than 1 day.
62 yrs. mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Co.Md.

PARENTS.

10-NAME OF FATHER Geo.O.Hunt,

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Co.Md.

12-MAIDEN NAME OF MOTHER Elizabeth Kinight,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Co.Md.

14- (Informant) Wm.Foster,
(Address) 1149 N.Stricker St.

15- Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). JUL 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 24 19 24 to July 25 19 24

that I last saw h.. alive on July 25 19 24

and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:—

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thyroid Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C R Davis M. D.

JUL 27 1924 19 (Address) 2108 Brookfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park DATE OF BURIAL JUL 29 1924 19....

20-UNDERTAKER. Geo W Little ADDRESS 2500 EDMONDSON AVE.

I. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Words should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 x 129 D 88953 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Paret Collins.

(a) Residence No. Guilford. Howard Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. mos. 5 ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 24. 1857

7-AGE: 67 yrs. ~ mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Deaconess P.E.

(b) General nature of industry, business, or establishment in which employed (or employer): Church

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Howard Co. Md.

PARENTS.

10-NAME OF FATHER: Ephriam Collins.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederivk Co. Md.

12-MAIDEN NAME OF MOTHER: Sarah D. Hammond.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Howard Co. Md.

14- (Informant): Mrs. Earp

(Address): Guilford Howard Co. Md.

15- Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): JUL 27 1924

17- I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to July 27, 1924, that I last saw h.e.r. alive on July 27, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstecal Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tuberculous Ludwig

(Signed) Edward A Morgan M. D.

JUL 27 1924 (Address) 1322 Hunter ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Homeward to Christ P.E. Church Std

DATE OF BURIAL, 19 JUL 29 1924

20-UNDERTAKER: Geo W Little

ADDRESS 2703 EDMONDSON AVE.

N. B.—WHITE PERMITS, WITH ORDERS FOR INTERMENT, ONLY ISSUED ON THIS CERTIFICATE. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Explanations and instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88954

CERTIFICATE OF DEATH.

129 D 88954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1347 N. Fremont Ave ST., 14 WARD)

2-FULL NAME Mariano Graziano

(a) RESIDENCE NO. 1347 N. Fremont Ave ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Graziano

6 DATE OF BIRTH (month, day, and year) 8/24/ 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Mc Graziano Italy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Martha Baltida Italy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Catherine Graziano

(Address) 1347 N. Fremont Ave.

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to July 25, 1924, that I last saw him alive on July 24, 1924 and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Diffuse Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs Symptoms

(Signed) R. C. Metzel, M. D.

July 28 1924 (Address) 1903 W. Eutaw av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL 7/28 1924

20 UNDERTAKER George J Ruth ADDRESS 1735 Hayford Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 88955

1-PLACE OF DEATH D 88955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital St., WARD)

2-FULL NAME Daniel Tyler

(a) RESIDENCE NO. 231 Pearl St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records

(Address)

15 Filed ....., 19 .... ROBERT R. KRAUTER, Registrar

JUL 28 1924 1644 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/24

17

I HEREBY CERTIFY, That I attended deceased from 7/23/24, 19.... to 7/25/24,

that I last saw h[illegible] alive on 7/25/24, 19,

and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Uremia

Malnutrition

Bilateral Inguinal Hernia

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Hirschsprung's Disease

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gilley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health;

Per. Wm. E. Woodall

JUL 28 1924

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Name ?

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 88956

D 88956 CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Mulliken ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Nance

(a) RESIDENCE No. 1731 Mulliken ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Dave Hamner.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C

12 MAIDEN NAME OF MOTHER Martha Nance

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C

14 Informant Martha Nance
(Address) 1731 Mulliken

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar
1637
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-1924

17

I HEREBY CERTIFY, That I attended deceased from 7-24-, 1925, to 7-25-, 1924,

that I last saw h alive on 7-24-, 1924,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

7 mo.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Hamner, M. D.

7-25-1924 (Address) 611-N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

230

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88957 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88957

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Home for the Aged St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Wentz

(a) Residence No.. Little Sisters of the Poor St., Preston Ward Fallsway

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 81 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Wentz

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Bixler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Sister Josephine

(Address) Little Sisters of the Poor Balt. Md

15- Filed July 29 1924 ROBERT R. KRAUTER Registrar.

JUL 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 28/24

17- I HEREBY CERTIFY, That I attended deceased from No Record, 19..., to ..., 19...

that I last saw him alive on July 27 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allan Craig, M. D.

7-29-24 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Green Mount Cem.	July 29, 1924

20-UNDERTAKER.	ADDRESS
Wilbur W. Shriver	1018 Edmondson Ave

N. B.—WHITE PAPER, WRITE PLAINLY. Every question must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88958

CERTIFICATE OF DEATH.

118-002 D 88958

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 7 WARD)

2-FULL NAME Walter Block

(a) RESIDENCE NO 2039 E. Eager St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 6/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER Robert Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER RosaZusmunowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Robert Block
(Address) 2039 E. Eager St

15 JUL 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July28/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Intussuception

(Operation)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Pollitzer, M. D.
(Coroner.)

7/28/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehew Southern Ave DATE OF BURIAL July 28 192

20 UNDERTAKER J Lennon Bro ADDRESS 112 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88959

D 88959

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew Orphan Asylum St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schwartz

(a) Residence No. 2100 E. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto St

15- JUL 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 27 1924

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to July 27 1924

that I last saw h[illegible] alive on July 27 1924

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Hutchorne, M. D

, 19 (Address) 810 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rodelph DATE OF BURIAL. July 29 1924

20-UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. (See should be carefully supplied, in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

88960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88960

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Calhoun & Lexington ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia B. Sellman

(a) RESIDENCE. NO. 1424 N. Lexington ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South River Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER Dr. John H. Sellman

11 BIRTHPLACE OF FATHER (city or town) A. A. Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Virginia M. Harwood

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Anne Arundel Co. Md

14 Informant Ella Z. Jones
(Address) Aged Woman's Home

Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924.

17

I HEREBY CERTIFY, That I attended deceased from July 2 . 1924 . to July 24 . 1924
that I last saw h e alive on July 24th . 1924
and that death occurred, on the date stated above, at 10.30 PM m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Circumstances

(Signed) Jas. T. Hooper , M. D.

July 27, 1924 (Address) 346 E. 28 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Call Hollows Church Camp Parole A. A. Co	July 29 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 88961

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Etting ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthon Johnson

(a) RESIDENCE NO. 1137 Etting ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholla Johnson

6 DATE OF BIRTH (month, day, and year) June 15th 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
37	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 060

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Mines

(c) Name of employer Millerton

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Nicholla Johnson (Address) 1137 Etting St.

15 Filed JUL 26 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1924, to July 26th, 1924

that I last saw h... alive on July 25th 24

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis M. D.

19 (Address) 922 Fawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL July 29, 1924

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88962

CERTIFICATE OF DEATH.

1 ✓ D 88962

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Ensor St ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita M. Montgomery

(a) RESIDENCE No 922 Ensor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) April 23/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER John Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Clara M Frisby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant John Montgomery
(Address) 922 Ensor St

15 Filed ....., 192 .....
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

(Signed) J. J. Wallis, M. D.
(Coroner.)

7/27/24 192 (Address) 508 E. NorthAve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem — DATE OF BURIAL July 28th 192 4

20 UNDERTAKER George J. Rust — ADDRESS 1735 Harford ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88963

CERTIFICATE OF DEATH.

D 88963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 5 WARD)

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guiseppe Maranto

(a) RESIDENCE No. 392 Forrest St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Maranto

6 DATE OF BIRTH (month, day, and year) Sept 25/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Maranto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Meranmina Gentile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ttaly

14 Informant Salvator Gentile
(Address) 392 Forrest St.

15 Filed JUL 28 1924 192 ROBERT N. [illegible], Registrar
Burial Permit Cl

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Peritonotis-Hemorrhage
(Bullet wound thru spleen &stomach)
Homicide
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Wallace, M. D.
(Coroner.)

7/27/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cem.	July 28th 1924
20 UNDERTAKER George J. Rent	ADDRESS 1735 Harford ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88964 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 Schafer ave St. 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armin Jaeger

(a) Residence No. 13 Schafer ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louise Jaeger

6-DATE OF BIRTH (month, day and year) April 28th 1853

7-AGE, 71 yrs. 2 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Christian Jaeger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Seibert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Wm. J. Jaeger

(Address) No. 9 Schafer ave

15-

Filed JUL 28 1924 ROBERT R. KRAUT Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26 - 24

17- I HEREBY CERTIFY, That I attended deceased from Aug - 1923 to July - 26 1924

that I last saw h — alive on July 26 1924

and that death occurred, on the date stated above, at 7.07 P. m.

The CAUSE OF DEATH* was as follows:

Malig. Dis - Eyes - Sarcoma Choroid -

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion —

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Frank C Bratton, M. D.

, 19 (Address) 125 E Biddle —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, July 27th 1924

20-UNDERTAKER, George Schilling & Sons ADDRESS 1136 Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 88965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 88965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Roland Ave R.P. ST., 13 WARD)

2-FULL NAME Mary Graham

(a) RESIDENCE No. 219 Roland Ave R.P. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daniel Graham

6 DATE OF BIRTH (month, day, and year) Born Nov 7th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Belfont Va
(State or country)

PARENTS

10 NAME OF FATHER William Oswald

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Mr Graham
(Address) 219 Roland Ave R.P.

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to July 27, 1924, that I last saw h.. alive on July 27, 1924, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Debilitation
Pulmonary Oedema
(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) Chr. Lobar Endocarditis
(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J. Spencer Brown M.D.

7/27 1924 (Address) 2846 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL July 28 1924

20 UNDERTAKER Henry W Jenkins Sons Co — ADDRESS Oliver & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Maria Larrabee

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Hebron Hosp 129

REGISTERED No. D 88966

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724 N Charles ST. 14 WARD)

2-FULL NAME Maria Larrabee

(a) RESIDENCE No. 1436 John St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): May 25th 1870

7 AGE: Years 54; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Daniel Larrabee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jennett Blubaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Stewart Larrabee

(Address): 1436 John St

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927 to July 27, 1927.

that I last saw h 24 alive on July 27, 1927.

and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1436 John St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Dr A Fattibene, M. D.

(Address) 2724 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: July 29 1924

UNDERTAKER: Geo M Jenkins, Sons — ADDRESS: Cathedral & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88967

CERTIFICATE OF DEATH.

154-002

D 88967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 601 W. Hamburg ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Henry Shaffner

(a) RESIDENCE NO. 601 W. Hamburg ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-24-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Adam Shaffner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Udaland Gurney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Adam Shaffner

(Address) 601 W Hamburg St

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to July 28, 1924, that I last saw h[illegible] alive on July 27, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M. Dilcrett, M. D.

July 28 1924 (Address) 621 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 7-28 1924

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 88968

D 88968

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Mullooly.

(a) RESIDENCE No. 613 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Orleans La.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know.

14 Informant Police Report. Central Dist.
(Address)

15 Filed JUL 28 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

July 27, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 613 N. Calvert St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C & Co	July 28 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88969

CERTIFICATE OF DEATH.

D 88969

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1820 Light St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Myers

(a) Residence No. 1820 Light St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 26 1913

7-AGE. 11 yrs. 29 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank R Myers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary A Tepper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mr Frank R Myers
(Address) 1820 Light St

15-
Filed ... 192.. ... Registrar.

OCT 28 1924 Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 25/924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 19 22 to Sept 25 19 24

that I last saw h[illegible] alive on July 25 19 24

and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Polyarthritis rheumatism

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

9/25, 19 24 (Address) 1 E Randall Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	July 28 1924
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—Form No. 7—1500 Blks.

D 88970
17358 9

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 88970

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 21 WARD)

2-FULL NAME Dorothy Koco (Kocher)

(a) RESIDENCE NO. 1407 Eastern ST ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Ostend Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): gtt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Henry Koco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER Elz. Rupert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): J. Counties JOHNS HOPKINS H. SPITAL

14 Informant

(Address)

15 JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23. 1924 to July 26. 1924.

that I last saw h alive on July 26 1924

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

acute gastro-Intestinal Indigestion.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1407 ostend St

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) S. F. Rawlins M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, Brooklyn — DATE OF BURIAL July 29 1924

20 UNDERTAKER: Wm Cook — ADDRESS 507 E. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Scott)

D 88971

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-D 88971

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 N Madeira St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph Scott

(a) Residence No. 703 N Madeira St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occured 35 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. 0 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Scott

6-DATE OF BIRTH (month, day and year) 1864

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cigar Worker

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14-(Informant)..... Anna Scott

(Address)..... 703 N Madeira

15-Filed JUL 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH. July 26

16-DATE OF DEATH (month, day and year). July 26-1924

17-I HEREBY CERTIFY, That I attended deceased from July 17, 19 24, to July 26, 19 24, that I last saw h.. alive on July 26, 19 24, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

..... (a) Acute Hart Pneumonia

.....

.....

.....(Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed)..... M. D.

7/27, 19 24 (Address) 1430 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer DATE OF BURIAL, July 29, 19 24

20-UNDERTAKER, Frank Ewen & Son ADDRESS 1106 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

REGISTERED NO. D 83972

1-PLACE OF DEATH St Joo Hospital

CITY OF BALTIMORE: (No. [illegible] ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas a Dawson

(a) RESIDENCE No. 818 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Circulation Dept. News Paper.

(b) General nature of industry, business, or establishment in which employed (or employer) Newspaper Dept.

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore md.
(State or country)

PARENTS

10 NAME OF FATHER John J. Dawson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Teresa McGaw

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Anna M. Dawson

(Address) 818 E. Preston St.

Filed JUL 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24th, 1924, to July 26th, 1924, that I last saw him alive on July 26th, 1924, and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intest Obstruction & Mesenteric Thrombis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At one

Did an operation precede death? yes Date of July 26th/24

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) H. B Sybert M. D.

19 (Address) St Jos. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 7/29/24

UNDERTAKER H C Wedefeld

ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88973

CERTIFICATE OF DEATH.

X 71-002 ✓ D 88973

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1214 Light St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Leroy Maddox

(a) Residence No. 518-4th St., S.E. Washington D.C. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Dec. 7 1910

7-AGE. 13 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Rowlandville, Md.

PARENTS.

10-NAME OF FATHER. Rev. Carroll Maddox

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Front Royal Va.

12-MAIDEN NAME OF MOTHER. Mabel L. Rice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Frederick Co. Md.

14- (Informant) Rev. Carrol Maddox
(Address) 518-4th St. S.E. Wash. D.C.

15- JUL 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 28 1924

17- I HEREBY CERTIFY, That I attended deceased from July 27 19.. to July 28 19..
that I last saw him alive on July 28 19..
and that death occurred, on the date stated above, at 4.45 A. M.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (Meningitis)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Eruption Only

(Signed) Dwight B. Kell M. D.

July 28 24 (Address) 1203 Light

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BERIAL. 7/30/24 19....

20-UNDERTAKER. Jos. F. Deering ADDRESS 765 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001 B 88974

CERTIFICATE OF DEATH.

88974

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St. Baltimore Ward) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gloria Boag

(a) Residence No. 40 S. Fulton Ave St. Bald. Md. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, ~~Widowed~~, or ~~Divorced~~. (~~Write the word.~~) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Boag

6-DATE OF BIRTH (month, day and year) June 29-1878

7-AGE. 60 yrs. ..... mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Spain

PARENTS.

10-NAME OF FATHER: do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): " " "

12-MAIDEN NAME OF MOTHER: " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): " " "

11-(Informant) husband - Alfred Boag
(Address) 40 S. Fulton Ave.

15-FILED JUL 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 21st, 1924, to July 27th, 1924, that I last saw her alive on July 27th, 1924, and that death occurred, on the date stated above, at 2.35 A.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Acute Cardiac
Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) disease — Chr. cardio renal & Emphysema ?
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/25/24

Was there an autopsy? No

What test confirmed diagnosis? Typhoid

(Signed) H Harper M. D
, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 29, 1924

20-UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88975

CERTIFICATE OF DEATH.

17 D 88975

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 10 WARD)

2-FULL NAME Clara Ehrlein

(a) RESIDENCE NO. 1213 Wilcox ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School girl.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Ehrlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Loretta Upton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hospital Record.

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/1924

17

I HEREBY CERTIFY, That I attended deceased from 7/21/24, 19 , to 7/27/24, 19 .

that I last saw h alive on 7/27/24, 19

and that death occurred, on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis of Peritoneum.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	7/30 1924

20 UNDERTAKER Wm. Rudefeld ADDRESS 914 Greenmount Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 38976

1-PLACE OF DEATH D 38976

REGISTERED NO. D 38976

CITY OF BALTIMORE: (No. Colonial Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hemple

(a) RESIDENCE NO. 61 Fair Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 22 min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. Schaffer

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma June Hemple

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant
(Address)

15 Date received JUL 28 1924

ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1924, to July 26, 1924, that I last saw him alive on July 26, 1924, and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Premature child - 5 mo -
due to injury

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. evidence

(Signed) A L Mammen M. D.

July 26 1924 (Address) Col. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,
per Wm. F. WOODALL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Frank Jdzi.

Spec.—1-10-21—M&T—1500 Bks.

D 88977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 88977

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S Port St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jdzi

(a) RESIDENCE NO. 713 S Port ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Sing

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12-24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Frank Jdzi

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jedzedadka

13 BIRTHPLACE OF MOTHER (city or town) Balt.
(State or country) md

14 Informant Frank Jdzi.
(Address) 713. S. Port St.

15 Filed JUL 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1924

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1924, to July 27, 1924, that I last saw h[illegible] alive on July 27, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

~~Bradley Myocarditis~~
Acute Dilatation

(duration) yrs. mo 21 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Francis J Dinkins M. D.

, 192 (Address) 3326 Pelt Wk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 29-1924
20 UNDERTAKER W F. Sadowski.	ADDRESS 705 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88978

113 D 88978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Hugo Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Kenneth Acker

(a) RESIDENCE. No. 2702 Hugo ST., Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Boy	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July, 15, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Joseph A. Acker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ethel Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Joseph A. Acker
(Address) 2703 Hugo Ave

JUL 28 1924

ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1924, to July 27, 1924, that I last saw him alive on July 26, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Ileo - Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Spasmo.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

7/27 1924 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7/28 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88979

CERTIFICATE OF DEATH.

113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1633 N Gay St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Raymond Whiteford Jr

(a) Residence No. 1633 N Gay St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 28-1923.

7-AGE, ... yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9-BIRTHPLACE (city or town) (State or Country), city

PARENTS.

10-NAME OF FATHER, Wm Whiteford

11-BIRTHPLACE OF FATHER (city or town) (State or Country). city

12-MAIDEN NAME OF MOTHER, Myrtle V. Seward

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). city

14- (Informant) Wm Whiteford Sr

(Address) 1633 N Gay St

15- Filed ..... 16- Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 27/24

17- I HEREBY CERTIFY, That I attended deceased from July 23, 1924 to July 27 1924

that I last saw him alive on July 27 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pleu Pulitis (Acute)

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert Sungenfeld M. D

7/28/ 1924 (Address) 613 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL July 29 1924

20-UNDERTAKER Wm J Tuckwell Son — ADDRESS North Ave

JUL 28 1924

Burial Permit Issued

USE B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38980

CERTIFICATE OF DEATH.

91-002 D 38980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1305 N Calvert ST., 17 WARD)

2-FULL NAME Marie Mullen

(a) RESIDENCE NO. 1305 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of –
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. ~~1842~~ 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~76~~	77	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none (W)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Mullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie McKenna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Bessie Keech
(Address) 1305 N Calvert St

15 Filed ....., 19 ..... Registrar

JUL 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to July 26, 1924, that I last saw her alive on July 26, 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 3 yr.
Senile Dementia 1 Yr.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Oedim of Lungs
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw. V Coolahan M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 5 or 6 Days

20 UNDERTAKER William Cook — ADDRESS July 28/24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88981

CERTIFICATE OF DEATH.

D 88981

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Hollins ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ann Forrest

(Residence in Baltimore: No. 1710 Hollins St St.; 6 yrs., 8 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	White	Single

6-DATE OF BIRTH, Feb 9, 1852 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 7 mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Tyler Forrest

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary A. Jean

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie W. Nicholson

(Address) 1710 Hollins St.

15-

Filed Robert P. Harrison, 191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10 1923, to July 27 1924, that I saw h[illegible] alive on July 23 1924 and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. 3 mos. 17 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) yrs. mos. ds.

(Signed) Geo. H. Bockman M. D.

, 191... (Address) 5866 Gotha

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Forest Cem	July 30, 191...
20-UNDERTAKER Joseph B. Cook	ADDRESS 1063 Hollins

BL 28 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88982

CERTIFICATE OF DEATH.

D 88982

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Greene & Lombard ST., 15 WARD) 117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund John Little

(a) RESIDENCE NO. 2401 Garrison Boulevard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W. hite

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Selma Little

6 DATE OF BIRTH (month, day, and year): Dec. 22, 1889

7 AGE — Years: 34 — Months: 7 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B. & O. Railroad

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Edmund J. Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary Newtown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Oakland Md.

14 Informant: Hospital Records

(Address): Greene & Lombard Sts.

Filed JUL 28 1924, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1924

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 27, 1924.

that I last saw him alive on July 27, 1924

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Paralytic Ileus

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? Yes Date of July 14/24

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) M. Edwards. M. D.

7-28-24 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: July 29 19

20 UNDERTAKER: Wm. H. Cook — ADDRESS: 103 Mott

WARNING—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 88983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 25 Ward) 11

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... George Albert Ford

(a) Residence No. 325 Patapsco St., W. Ft. Winans Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 2nd, 1916

7-AGE, 7 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... School boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore County (State or Country) Maryland

PARENTS:

10-NAME OF FATHER, Eugene W. Ford

11-BIRTHPLACE OF FATHER (city or town) Baltimore County (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ada McJilton

13-BIRTHPLACE OF MOTHER (city or town) Baltimore County (State or Country), Maryland

14- (Informant) Mrs. Eugene Ford

(Address) 325 Patapsco Street

15- Filed JUL 28 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 23, 1924 to July 26, 1924 that I last saw him alive on July 26, 1924 and that death occurred, on the date stated above, at 12 mid night m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
- ruptured - General peritonitis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of July 23, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative findings

(Signed) Wm. J. Fulton M. D.

7-26-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monkton Md	July 28 1924
20-UNDERTAKER. Jos L Lark	ADDRESS 1003 W Balto

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88984

CERTIFICATE OF DEATH.

56 D 88984

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 S. Sharp Street. ST., 23 WARD)

2-FULL NAME Lawrence A. Meyers Jr.

(a) RESIDENCE NO. 1244 S. Sharp Street. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Lawrence A. Meyers

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna L. Kwedar

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Anna L. Meyers. (mother)
(Address) 1244 S. Sharp Street

15 Filed JUL 28 1924 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th, 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1924. to July 26th, 1924.
that I last saw him alive on July 26th, 1924.
and that death occurred, on the date stated above, at 12.05 p. m.

The CAUSE OF DEATH* was as follows:

Rachitis.
Acute dilatation of the Heart.
Oedema of the Lungs.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm. M. Reinhardt, M. D.

7-27 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL July 29 1924

20 UNDERTAKER Frost & Brooks ADDRESS 1003 N. Calvert St.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Bks.

D 88985 / 17 8985 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 88985

JOHNS HOPKINS — CERTIFICATE OF DEATH. — 36.004

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel A. Wattman

(a) RESIDENCE No. 109 Churchill St. ST. Keen Rock, Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 12 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Barbara A. Wattman

6 DATE OF BIRTH (month, day, and year) Oct 16 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggest

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER William Wattman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Tentoway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, Registrar

JUL 28 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 28, 1924, that I last saw him alive on July 28, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Uremia.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Tbc Genital Tract

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of July 21-24

Was there an autopsy? Yes

What test confirmed diagnosis? Anatomical findings

(Signed) Robert P. Harrison, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburgh Pa.

DATE OF BURIAL 7/28/24

20 UNDERTAKER H. E. Hughes & Son

ADDRESS W. Broadway

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88986

CERTIFICATE OF DEATH.

D 88986

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 Grindon Ave Lauravisle 27 WARD)

2-FULL NAME J. Frederick Wetzel

(a) RESIDENCE NO 35 Grindon Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Wetzel

6 DATE OF BIRTH (month, day, and year) March 19/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retire Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John W. Wetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie M. Blenker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Willine (Daughter)
(Address) 35 Grindon Ave

15 Filed ..... 192 Robert P. Harrison, .
Registrar
Burial Permit Clerk.

JUL 28 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Arteriosclerosis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History-Appoplexy 2 yrs ago (duration) yrs. mos. ds.

(Signed) J. S. H. Patten, M. D.
(Coroner.)

7/28/24, 192 (Address) 508 E. north Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL July 29 1924

20 UNDERTAKER Fredk Lassahn Sons — ADDRESS Fullerton

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED FOR RECORDING DATA.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88987

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1916 W. Pratt ST., 20 WARD)

2-FULL NAME Lula A. Ulbrich

(a) RESIDENCE NO. 1916 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct. 8-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William C. Ulbrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Ulbrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa

14 Informant Mrs. Louisa Ulbrich

(Address) 1916 W. Pratt St.

15 Filed JUL 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1924 to July 26, 1924 that I last saw h... alive on July 26, 1924 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. F. Longshore M. D.

(Address) 1 E. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 29 1924

20 UNDERTAKER George L. Schwartz ADDRESS 1101 Ludlow

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88988

CERTIFICATE OF DEATH.

113 D 88988

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John s Hopkins Hospital WARD) 2

2-FULL NAME Joseph Slachetka Jr

(a) RESIDENCE No. 619 S.Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Sept 7/1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Slachetka

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER May Sobczynski

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jos. Slachetka
(Address) 619 S. Bond St

15 Filed JUL 28 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestio

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Hurst M. D.

7/28/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus DATE OF BURIAL 7/29 1924

UNDERTAKER William Galloway & Sons ADDRESS Eastern

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS DATA FURNISHES RECORDS, FACTS AND STATISTICS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88989 | CERTIFICATE OF DEATH. | 88989

1-PLACE OF DEATH: University Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Mills

(a) RESIDENCE NO. Carnegie Ave., ST., Grace Park WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ~ mos. 1 ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced (c1) HUSBAND of / WIFE of albert W. Mills

6 DATE OF BIRTH (month, day, and year) Feb. 20th, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Sydnol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa McKewen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Edith Hamilton (Address) Dundalk

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 28, 1924, that I last saw her alive on July 24, 1924, and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows: ~

Carcinoma of Gall Bladder with metastasis. Duct, causing fecal intestinal obstruction

(duration) 3 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) ~ (duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? yes Date of July 27, 1924

Was there an autopsy? ...

What test confirmed diagnosis? Gen. + roentgen + clinic

(Signed) H. R. Ellison, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, D. C. | DATE OF BURIAL July 29th 1924

20 UNDERTAKER E. J. Fanning & Son - 1938 | ADDRESS E. Lafayette Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

17350 D 88990 — D 88990 — 129 D 88990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Dalton

(a) RESIDENCE No. 8th St. Fairfield Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Walter Dalton

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ....min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day work

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Henry McNeely

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER Martha Peary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 29 1924 ROBERT S. KRAUTER, Registrar

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1924 to July 27, 1924, that I last saw him alive on July 27, 1924 and that death occurred, on the date stated above, at 4.03 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Hypertension

(duration) 3? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis? autopsy

(Signed) T. R. Harmon, M. D.

7/28, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. — DATE OF BURIAL July 30 1924

20 UNDERTAKER Wm J. G. Locke — ADDRESS 1302 Jeffers

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 88991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilmon Thomas

(a) RESIDENCE NO. 826 Warner Sr. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. ?, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	10	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James H. K. Thomas
(Address) 230 W. Cross St.

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) automobile accident.

(duration) ... yrs. ... mos. ... ds.

(Signed) J. E. Hennessy, M. D.
(Coroner.)

July 26 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 30 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1412 Mt. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33

D 88992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 W. West Street ST., 27 WARD)

2-FULL NAME Vivian M. Sewell. (C).

(a) RESIDENCE NO 531 W. West Street. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) April 26, 1918.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	3	1.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clarence Sewell(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nettie McLaughlin(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Nettie Sewell(C)(mother).
(Address) 531 W. West Street.

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis.

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

July 28. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 28 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1423 Eutaw St.

NOTE: WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001

D 38993

REGISTERED NO. D 38993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 N. Gilmor St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Thomas

(a) RESIDENCE No. 1408 N Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (adopted child)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Lizzie Thomas
(Address) 1408 N. Gilmor St.

15 Filed JUL 29 1924 ROBERT F. KRAUTER, Registrar
Burial Permit Clark.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

July 27, 1924 (Address) 288 Reed Saratoga ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters	7/29 1924
20 UNDERTAKER Franklin W Setz	ADDRESS 1033 2d St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88994

CERTIFICATE OF DEATH.

46 D 88994

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dicie Goldsboro

(a) Residence No. 6 N. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), S. Carolina

PARENTS.

10-NAME OF FATHER, W. Heavey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) S. Carolina

12-MAIDEN NAME OF MOTHER L. Stevenson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) S. Carolina

14- (Informant) Son Wm

(Address) Woods

15- JUL 29 1924 ROBERT R. KRAUTER, Registrar.

(1914) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/25/24

17- I HEREBY CERTIFY, That I attended deceased from June 23, 1924 to July 25, 1924

that I last saw h.. alive on July 22, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary

General metastasis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 19, 24

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological & Clinical Findings

(Signed) Wm. S. Gallen, M. D.

, 19 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Bonnettsville S. C. DATE OF BURIAL 7/29/24

20-UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88995

CERTIFICATE OF DEATH.

38 D 88995

1-PLACE OF DEATH Out the lawn in front

CITY OF BALTIMORE (No. 4406 Groveland Ave ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Huff.

(a) RESIDENCE NO. 927 Druid Hill Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Huff

6 DATE OF BIRTH (month, day, and year) About 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 27
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Huff (Address) 927 Druid Hill Ave

15 Filed JUL 29 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) , yrs. mos 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

July 28 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7/29 1924

20 UNDERTAKER Dan'l Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88996

CERTIFICATE OF DEATH.

74-001

D 88996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 Millaman St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Stemler

(a) RESIDENCE No 2330 Millaman St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Stemler

6 DATE OF BIRTH (month, day, and year) Nov 4/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Brick Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Stemler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Maggie Stemler
(Address) 2330 Millaman St

15 Filed JUL 29 1924 ROBERT A. KRAUS Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

(Signed) J. J. H. Cullen, M. D.
(Coroner.)

7/26/24, 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	July 28 24
20 UNDERTAKER	ADDRESS
Jas C. Miller	233 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXCEPTIONAL CARE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE, if LESS than one day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88997 46 D 88997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 N Milton ave St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lenna Berry

(a) Residence No. 519 N Milton ave St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of J W Berry

6-DATE OF BIRTH (month, day and year) Not known

7-AGE. About 64 yrs. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Not known

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not known

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

14- (Informant) J W Berry

(Address) 519 N Milton ave

15- JUL 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 28 24

17- I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to July 27, 1924, that I last saw her alive on July 26, 1924, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Scarr, M. D.

7-27, 1924 (Address) 3907 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cremation Co

DATE OF BURIAL. July 30 1924

20-UNDERTAKER. Jas E. Miller

ADDRESS 2334 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 88998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 N. Central Ave ST. 10 WARD)

2-FULL NAME Dora Unkelbach

(a) RESIDENCE NO. 1044 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Unkelbach

6 DATE OF BIRTH (month, day, and year) Jan. 26 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Ullrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Peter Unkelbach

(Address) 1044 N. Central Ave

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

I HEREBY CERTIFY, That I attended deceased from June 28 1924 to July 27 1924

that I last saw h[illegible] alive on July 27 1924

and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) J. H. Scheuner M. D.

, 19 (Address) 119 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 30 1924
20 UNDERTAKER	ADDRESS
Henry Hoock Son	1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88999

88999

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 E. Chase ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline V. Vees

(a) RESIDENCE NO. 1414 E Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? 74 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Vees

6 DATE OF BIRTH (month, day, and year) Feb. 5th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER F. Bader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Chas. E. Meade

(Address) Gott Motor A.A.Co. Md.

15 JUL 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 19 24 to July 27 19 24, that I last saw h alive on July 27th, 19 24, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Contributory Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Cone M. D.

July 28 19 24 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL July 30 19 24

20 UNDERTAKER Henry Hoech Son ADDRESS 1501 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89000

99-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N. Eden st ST., 10 WARD)

2-FULL NAME Mary Josephine Knoche

(a) RESIDENCE NO 904 N. Eden St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES and ANSWERS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Franz Knoche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Schnedler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: C. A. Fink & Son
(Address): 915 N. Gay St.

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Dilitation

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis-Senile

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Paden, M. D.
(Coroner.)

7/29/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 29 1924
20 UNDERTAKER: Frank A. Fink	ADDRESS: 915 N. Gay St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89001 — CERTIFICATE OF DEATH. — X32 — D 89001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Oxford ST., 17 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fedora Buckenmeyer

(a) RESIDENCE No. Pinebrook, N. J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8d ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Color	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Buckenmeyer

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33-33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Buckenmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Shindler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Donald Buckenmeyer (Address) 731 Oxford

15 JUL 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2 VII, 1924 to July 27, 1924, that I last saw h alive on July 27, 1924, and that death occurred, on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Infected Ear

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Pinebrook, N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1924 (Address) St. Paul's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 29
20 UNDERTAKER	ADDRESS
Samuel Wendell	Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 89902

CERTIFICATE OF DEATH.

113. D 89902

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2133 E North Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruce Ellwood Lesher Jr

(a) Residence No. 2133 E North Ave St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 13 1923

7-AGE. 1 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER Bruce Ellwood Lesher

11-BIRTHPLACE OF FATHER (city or town) Centreville (State or Country), Md

12-MAIDEN NAME OF MOTHER Lula May Pinkett

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) Bruce E. Lesher Sr

(Address) 2133 E. North Ave

15- JUL 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 14 1924 to July 26 1924

that I last saw h.. alive on July 26 19 24

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr D Wheaton, M. D

, 19 (Address) 4-89 4K 29-

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL. 7/29 1924

20-UNDERTAKER. George J Ruth

ADDRESS 1735 Hanford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89003

CERTIFICATE OF DEATH.

90 D 89003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 N Spring ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jenkins

(a) RESIDENCE NO. 1816 N. Spring ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Rachel Jenkins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
appox	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Josephine Murray daughter 374 Milton Ave

15 Filed JUL 29 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1924

17 I HEREBY CERTIFY, That I attended deceased from July 21 1924 to July 27 1924 that I last saw him alive on July 26 1924 and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(duration) yrs. unknown mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Gosling, M. D.

7-28 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Pleasant Rest Cem. DATE OF BURIAL July 29 24

20 UNDERTAKER Mrs Rda. Elliott. ADDRESS 1725 Oakland

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89004

CERTIFICATE OF DEATH

146

D 89004

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No.....St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Jones

(a) Residence No. 641 Steuart St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6-DATE OF BIRTH (month, day and year) 1906

7-AGE. 18 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Leo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14-(Informant) Bay View Hosp.

(Address)

JUL 29 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26, 1924

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1924 to July 26, 1924

that I last saw h[illegible] alive on July 26, 1924

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia (Strep. Pyogenes)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fever & Puerperal Psychosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. Feldsmith M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lamel Cemetery

DATE OF BURIAL, July 30 1924

20-UNDERTAKER, Mrs. P. C. Elliott

ADDRESS 1725 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Eks.

D 89005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89005

CERTIFICATE OF DEATH.

25 18-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella J. Miller.

(a) RESIDENCE NO 104 N. 6th, St. Brooklyn. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~ ~~HUSBAND OF~~ (Or) WIFE of Herman Miller.

6 DATE OF BIRTH (month, day, and year) September 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Thomas J. Miller. (Nephew).

(Address) 1227 William Street.

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck and knocked down by an automobile while crossing the street. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

July 29, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 1st. St. & Annapolis Ave. Brooklyn. July 26, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 29 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39005

CERTIFICATE OF DEATH

100-09 D 39006

1-PLACE OF DEATH Municipal Hospital

Registered No.....

City of BALTIMORE: (No. Municipal Hospital Blvd A St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Odensoos

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Geoge Odensoos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Records

(Address)...

15- JUL 29 1924 ROBERT R. KRAUTER, Registrar.

1647 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26-1924

17- I HEREBY CERTIFY, That I attended deceased from June 30 19 24 to July 26 19 1924

that I last saw h[illegible] alive on July 26 19 24

and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH was as follows:

Senile Pneumonia Left

Lung Secondary to Definite

Arteriosclerosis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? Yes Date of July 17-24

Was there an autopsy? No (Removal of Tonsils)

What test confirmed diagnosis? Clinical Tests

(Signed) Jno. F. Champe, M. D.

Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER,	ADDRESS

JUL 29 1924

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89007

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Rosekemp ave St., 27 Ward)

Registered No.....

2-FULL NAME. Mildred G. Schmier

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1 Rosekemp ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 31, 1923

7-AGE. ..... yrs. 11 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry Schmier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mildred White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Harry Schmier

(Address) 1 Rosekemp ave

15- FILED JUL 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 28, 1924, that I last saw her alive on July 28, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pertussis

~~Influenza~~ (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Henry Lyman Mattila M. D.

, 19 (Address) 1229 Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Parkwood	7/30/24
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1134 Eager

MAROON RECORD—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89008 ✓ 289008

CERTIFICATE OF DEATH.

80068 A

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Municipal Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Richardson

(a) RESIDENCE. No. 3rd ave. 44 St. Fairfield WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Richardson

6 DATE OF BIRTH (month, day, and year) Sept 26 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Tho. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Municipal Hospital Records (Address)

15 Filed JUL 29 1924 19.. ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-24, 1924, to 7-27, 1924, that I last saw h[illegible] alive on 7-27, 1924 and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

Miliary Tuberculosis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Drew, M. D.

7-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	July 31 1924
20 UNDERTAKER	ADDRESS
Urban Troop - Pier E Work	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

89009

HEALTH DEPARTMENT—CITY OF BALTIMORE

89009

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arbey Chew

(a) RESIDENCE No 234 Rock St ST., WARD Camp Parole.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colo	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Plenty.

9 BIRTHPLACE (city or town) Camp P. Poole.
(State or country) Country

PARENTS

10 NAME OF FATHER Charles Chew

11 BIRTHPLACE OF FATHER (city or town) Mt Zion
(State or country) Country

12 MAIDEN NAME OF MOTHER C. Chew.

13 BIRTHPLACE OF MOTHER (city or town) Mt Table
(State or country) Country.

14 Informant Charles Chew.
(Address) Camp Parole Md.

15 Filed JUL 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 26th July 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Internal Injuries a few hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by Auto

(Duration) yrs. mos. ds.

(Signed) D H Gruel, M. D.
(Coroner.)

7 29 1924 (Address) 1177 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery DATE OF BURIAL July 29 1924

20 UNDERTAKER Charles Aleph ADDRESS 140 Dundalk Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89010

CERTIFICATE OF DEATH.

× 168

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barker Newhall

(a) RESIDENCE NO Gambier Ohio ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher of Greek
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Kenyon College

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Johns Hopkins Hospital (Address)

15 Filed JUL 29 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation-suicide-
(Used neck ties over bed post)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Porter, M. D.
(Coroner.)

7/29/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Vernon Ohio DATE OF BURIAL July 29 1924

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89011 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89011

CERTIFICATE OF DEATH. 4 113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 670 W. Saratoga St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Esposito

(a) Residence No. 670 W Saratoga St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 4/18/24

7-AGE,	If LESS than 1 day,
..... yrs. 5 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Julius Esposito

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Cornelia Palmieri

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Julius Esposito

(Address) 670 W Saratoga

15- Robert P. Harrison, Registrar.

JUL 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-28-24

17- I HEREBY CERTIFY, That I attended deceased from July 23 1924 to 7-28 1924

that I last saw h. alive on 7-28- 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death? 670 W. Saratoga St.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gross & Path. Exs.

(Signed) D. C. Watts M. D.

7-29, 1924 (Address) 116 W Lexington St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral	Aug 6, 1924
20-UNDERTAKER, John Ulrich	ADDRESS 2908 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D 89012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 89012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E. 22nd St ST., 17 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Deck

(a) RESIDENCE No. 100 E. 22nd St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary D. Deck

6 DATE OF BIRTH (month, day, and year) 4 | 15 | 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Cream Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer) $75

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob S. Deck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Haase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary D. Deck
(Address) 1008 E. 20th St.

15 [illegible] 19 ..... Robert P. Harrison,
Registrar

JUL 29 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 5, 1924, to July 27, 1924, that I last saw h alive on July 27, 1924, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis Peritonitis
7 th-wk nurse

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 100 E 22nd St

Did an operation precede death? Yes Date of May 26, 24

Was there an autopsy? No

What test confirmed diagnosis? Usual sign

(Signed) J. J. Deck, M. D.

7/29, 19 24 (Address) 1106 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	7/30 1924
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89013

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 626 N. Fremont St., 16 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... William Augustus Rev. Barrett

(a) Residence No. 626 N. Fremont St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of ~~Last Wife of~~ Emma Barrett

6-DATE OF BIRTH (month, day and year) Nov. 18-1866

7-AGE. 57 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Civil Service Commission

(c) Name of employer Geo. W. Little

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Barrett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Barrett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs. Emma Barrett

(Address) 626 N. Fremont St.

15- Filed JUL 29 1924, 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29-1924

17- I HEREBY CERTIFY, That I attended deceased from June 17, 1924 to July 29, 1924 that I last saw h... alive on June 26 1924 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum test

(Signed) Thomas H. Wright M. D

, 19 (Address) 609 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn

DATE OF BURIAL. JUL 31 1924

20-UNDERTAKER. Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89914

CERTIFICATE OF DEATH.

1924 89914

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. Marine Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland S. Hothall

(Residence in Baltimore: No. 2535 St Paul Stret St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 16, 1899.
(Month) (Day) (Year)

7-AGE. 25 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S. gourrnment

9-BIRTHPLACE, (State or Country). Mayland.

PARENTS.

10-NAME OF FATHER, Jessie M. Hothall

11-BIRTHPLACE OF FATHER (State or Country). Mayland

12-MAIDEN NAME OF MOTHER Grace Schauch

13-BIRTHPLACE OF MOTHER (State or Country). Mayland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie M. Hothall

(Address) Parkton, Mayland

15- Robert P. Harrison,

Filed....., 192..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wounds
Throughbody
Homicide

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John M. Harrison M. D.
(Coroner.)

July 29 1924. (Address) 36 S. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Middletown Md Cemtery — DATE OF BURIAL, July 31, 1924

20-UNDERTAKER E. LeRoy Stifflen — ADDRESS 125 E. North Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

John Odenson ✓

D 89015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N. Fremont ST. 18 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Price

(a) RESIDENCE No. 524 N. Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred all 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow Oliver D. Price

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
age not known				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no occupation

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Buckingham Co Va

PARENTS

10 NAME OF FATHER: Richard M. Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Edward Co Va

12 MAIDEN NAME OF MOTHER: Elizabeth Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cumberland Co Va

14 Informant: Mrs Alice Reiche

(Address)

15 JUL 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1924, to July 25th, 1924, that I last saw her alive on July 25th, 1924 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of head of Femur on right side followed by malnutrition and emaciation

(duration) yrs. 6 mos 15 ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. mos. ds.

Over

18 Where was disease contracted if not at place of death? 6 or work Franklin

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Exam

(Signed) Amanda T. Harris, M. D.

19 (Address) 110 E. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Leatherbury | DATE OF BURIAL: July 30 1924

20 UNDERTAKER: [illegible] | ADDRESS: 500 E. York St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89016

CERTIFICATE OF DEATH.

129 D 89016

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Talker-

(a) RESIDENCE No. 1460 Reynold st- ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred dont know yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W White	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or (State or country) Germany

14 Informant (Address) Mrs Schumacher 1460 Reynolds st

15 Filed JUL 29 1924 16 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. dont know mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

(Signed) W. K. Forncrook, M. D. (Coroner.)

July 29. 1924 (Address)† 1717 Sarato st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 31 1924

20 UNDERTAKER Williams Cook — ADDRESS 502 E North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89017

CERTIFICATE OF DEATH.

X/87-05 89017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. American Sugar Refinery ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Whelan.

(a) RESIDENCE No. 1450 Covington St. ST., WARD Ireland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 8 mos. -- ds. How long in U. S., If of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of~~ - Catherine Whelan.

6 DATE OF BIRTH (month, day, and year) November 16, 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Plumbers Helper.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Whelan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Edward J. Whelan (brother). (Address) 1450 Covington St.

15 JUL 29 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28. 192 4.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushing injuries of the legs, thighs and body. Accidentally caught in a sugar conveyer.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto Reinhardt, M. D. (Coroner.)

July 29, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 30 192 4
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	14 rr Light

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Missing

#D 89018

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89019

CERTIFICATE OF DEATH.

100-08 B 89019

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST. 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willa M. Clifton

(a) RESIDENCE. No. 108 Warren Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Alexander Clifton

6 DATE OF BIRTH (month, day, and year) Oct 24 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Clifton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Mary Dashiell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Municipal Hospital Record (Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

JL 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-25 1924, to 7-28 1924

that I last saw her alive on 7-28 1924

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Detinuation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude A. Drane, M. D.

7-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Vienna Dorchester Co Md Bivd R.R.	July 30 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Eight St

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89920

CERTIFICATE OF DEATH.

D 89920

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1528 Latrobe Park Terrace St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Lesniewski

(a) Residence No. 1528 Latrobe Park Terrace St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 18 1921

7-AGE. 2 yrs. 7 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Peter Lesniewski

11-BIRTHPLACE OF FATHER (city or town). Poland
(State or Country).

12-MAIDEN NAME OF MOTHER, Emilia Czastkiewicz

13-BIRTHPLACE OF MOTHER (city or town). Poland
(State or Country).

14- (Informant) Mr Peter Lesniewski

(Address) 1528 Latrobe Park Terrace

JUL 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29/24

17- I HEREBY CERTIFY, That I attended deceased from July 18th 1924 to July 29 1924 that I last saw h[illegible] alive on July 29th 1924, and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Mitral stenosis

(Duration) ... yrs. 6 mos. ... ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) ... M. D

7-30- 1924 (Address) 2202 W North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cem.	July 30 .... 19 24
20-UNDERTAKER.	ADDRESS
John A. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Begus

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

D 89021

CERTIFICATE OF DEATH.

74 D 89021

1-PLACE OF DEATH

REGISTERED No. .....

CITY OF BALTIMORE: (No 109 Penn st ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Begus

(a) RESIDENCE No 109 Penn st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W. Szczepkies
(Address) 109 S. Fulton Ave

15 Filed JUL 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) a few mos. ds.

CONTRIBUTORY (Secondary) Dont know

(duration) ... yrs. ... mos. ... ds.

(Signed) W B Grinder, M. D.
(Coroner.)

7.29, 1924 (Address) 1171 Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Cemetery	July 31 1924

20 UNDERTAKER	ADDRESS
Chas B Kuchaus	637 S Paca

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY, in all cases, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89022

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 89022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1938 Christian St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. L. Black

(a) Residence No. 1938 Christian St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 23-1923

7-AGE. 1 yrs. 5 mos. ds. LESS than 1 day. hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER Wm H. Black

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Barbara A. Efel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md

14- (Informant) William H. Black

(Address) 1938 Christian St.

15- Filed JUL 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/28/24

17- I HEREBY CERTIFY, That I attended deceased from 7/27/24 19.. to 7/28/24 19..

that I last saw h.. alive on 7/28/24 19..

and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) Hrs. yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Levy, M. D

7/29/24 (Address) 910 W. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. July 30 19 24

20-UNDERTAKER. George L. Schwab — ADDRESS 61 Frederick Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Sargent St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Charles A McCain

(a) Residence No. 1135 Sargent St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1529-002

D 89023

Registered No.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 21-1924

7-AGE, ...yrs....mos. 8 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Le Roy McCain

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sophia Quantmayer

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Le Roy McCain

(Address) 1135 Sargent St

JUL 30 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29-1924

17- I HEREBY CERTIFY, That I attended deceased from 7/24/24, 19..., to 7/29, 19 24, that I last saw h[illegible] alive on 7/29, 19 24, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsett, M. D.

, 19 (Address) 1107 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cem. | DATE OF BURIAL, July 30 1924

20-UNDERTAKER, James Dignan & Son | ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

Getz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89024

100-001

D 89024

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 Clifveiw Ave., ... St., 8 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Tobie Getz .....

(a) Residence No. 1700 Clifview Avenue St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 2 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Getz

6-DATE OF BIRTH (month, day and year)

7-AGE. 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Morris Smuch

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Russia

14- (Informant) Morris J. Steel

(Address) 1700 Cliffview Ave.,

15- ROBERT N. KRAUTER,

Filed JUL 30 1924 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29-24

17- I HEREBY CERTIFY, That I attended deceased from July 20th 19.24 to July 29 19.24

that I last saw h.. alive on July 27 19 24

and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. A. Nicholson M. D

19 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bet Hakeram

DATE OF BURIAL. July 30 19 24

20-UNDERTAKER. Jack Levin

ADDRESS 1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89025

CERTIFICATE OF DEATH.

D 89025

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 134 S Eden Street St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pesach Baranofsky

(a) Residence No. 134 S Eden Street St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed~~, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rachel Baranofsky

6-DATE OF BIRTH (month, day and year) Unkown

7-AGE. 94 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): Old Age

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS

10-NAME OF FATHER. Unkown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unkown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

11- (Informant) Jack Lewis

(Address) 1439 E Baltimore St

15- JUL 30 1924 192. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7 29 24

17- I HEREBY CERTIFY, That I attended deceased from Ap. 25 1924 to July 29 1924

that I last saw him alive on " " 1924

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(Duration) — yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary etc

(Signed) Chas. C Conser M. D

7/30, 1924 (Address) 1101 N. Fulton Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL. 7 30 1924

20-UNDERTAKER. Jack Lewis 1439 E Balt St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89026

CERTIFICATE OF DEATH.

113 D 89026

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3408 Hickory Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Imarie E O'Brien

(a) Residence No. 3408 Hickory Ave St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 16 1924

7-AGE. 1 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank L O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Julia Corbin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Frank L O'Brien

(Address) 3408 Hickory Ave

15- JUL 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1924 to July 29, 1924, that I last saw her alive on July 29 1924 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis

(Duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Marasmus (Premature)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Mueller M. D

, 19 (Address) 4037 Falls Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Hampden — DATE OF BURIAL. July 30 1924

20-UNDERTAKER — ADDRESS C HENOWETH & SON 501 WALNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 89027

CERTIFICATE OF DEATH.

D 89027 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Rosedale Terrace ST.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alviara Brisco

(Residence in Baltimore: No. 403 Rosedale Terrace St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD.

N. B.—Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Oct (Month) 4 (Day), 1847 (Year)

7-AGE, 76 yrs. 9 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Toland

11-BIRTHPLACE OF FATHER (State or Country) Philadelphia Pa

12-MAIDEN NAME OF MOTHER Sarah A Toland

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alviara DeLaye Brisco

(Address) 403 Rosedale Terrace

15- JUL 30 1924 ROBERT R. KRAUTER, 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28/24 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26/24 191..., to July 28/24 191..., that I saw h.r. alive on July 28/24 191..., and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Right Side

Contributory Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Chronic Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) Henry B. Cole M. D.

July 29 1924 (Address) 1303 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem DATE OF BURIAL, July 31, 1924

20-UNDERTAKER Robert Brooksdale ADDRESS Calhoun Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2613 W. Fayette St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil J. Bonn

(a) Residence No. 2613 W. Fayette St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Augustine Bonn

6-DATE OF BIRTH (month, day and year) March 19. 1872

7-AGE, 52 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Glass Cutter 186

(b) General nature of industry, business, or establishment in which employed (or employer) Helsele Glass Mfg.

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) (State or Country), France

PARENTS.

10-NAME OF FATHER, August Bonn

11-BIRTHPLACE OF FATHER (city or Town) (State or Country), France

12-MAIDEN NAME OF MOTHER Adelia Joyeh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), France

14- (Informant) Augustine Bonn

(Address) 2613 W. Fayette St

15- BURIAL Permit Clerk. JUL 30 1924 Registrar.

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29th 24.

17- I HEREBY CERTIFY, That I attended deceased from July 22nd 1923, 19.... to July 29th 19 24, that I last saw h.. alive on July 29th 1924, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) yrs. 18 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Klaer M. D.

July 29, 1924 (Address) 801 N. Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery | DATE OF BURIAL July 31st 1924

20-UNDERTAKER F. S. Hilpert | ADDRESS 1850 W. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89029

CERTIFICATE OF DEATH.

X 12 D 89029

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 E. Montgomery St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel S Somers

(a) Residence No. 9 E. Montgomery St., ... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie M Somers

6-DATE OF BIRTH (month, day and year) April 12/865

7-AGE. 59 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Fairmont Somerset Co Md

PARENTS.

10-NAME OF FATHER. Samuel Somers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Fairmont Somerset Co Md

12-MAIDEN NAME OF MOTHER. Maria Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Fairmont Somerset Co Md

14-Informant Mrs Annie M Somers

(Address) 9 E Montgomery st

15-JUL 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 15 19 24 to July 29 19 24

that I last saw him alive on July 26 19 24

and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? N. K. Date of —

Was there an autopsy? N O

What test confirmed diagnosis? Exam. Urine

(Signed) Wm. Lee Howard, M. D.

July 30, 1924 (Address) 816 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oxford, Talbot Co Md

DATE OF BURIAL. JULY 30 1924

20-UNDERTAKER. John F Denny

ADDRESS. 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 39030

89030

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO 1915 N. Monroe ST., 15 WARD)

2-FULL NAME Mary Sullivan

(a) RESIDENCE. NO. 1915 N. Monroe ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Thomas Sullivan

6 DATE OF BIRTH (month, day, and year) Dec 26th 1858

7 AGE — Years 65 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) County Galway Ireland

PARENTS

10 NAME OF FATHER Michael Faherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Galway Ireland

12 MAIDEN NAME OF MOTHER Mary Mc Donough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Galway Ireland

14 Informant (Mrs) Mary M. Hess (Address) 1915 N. Monroe St

15 Filed JUL 30 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4th 1924 to July 28th 1924, that I last saw h[illegible] alive on July 28th 1924, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Paralytica (duration) 2 yrs. 11 mos. 23 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical & Clinical

(Signed) William J Sullivan, M. D.

7/29/1924 (Address) 1701 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL July 31 1924

20 UNDERTAKER M Tuskey & Sons ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1733-42. 113 D 89931

89931 JOHNS HOPKINS HOSPITAL.

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Albemarle St., 3 WARD)

2-FULL NAME Joseph ~~Salvatore~~ Monaco

(a) RESIDENCE NO. 502 Albemarle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Apr 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Valentino Monaco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Helen Pomonico

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1924, to July 29, 1924,

that I last saw him alive on July 29, 1924,

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea and vomiting (not dysentery)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A. A. Wiech, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Holy Redeemer DATE OF BURIAL July 31 1924.

UNDERTAKER Wendell Appel & Son ADDRESS 37 Lloyd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89032

CERTIFICATE OF DEATH.

122-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Quinn

(a) RESIDENCE. NO. 1800 White ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness-Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER William? Quinn

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine? Kane

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Ireland

14 Informant Municipal Hospital Records
(Address)

15 Filed JUL 30 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-29, 1924, to 7-29, 1924, that I last saw h~~im~~ alive on 7-29, 1924 and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver (Laennec)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Brace, M. D.

7-30 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 31st 1924
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be of importance. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89033

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 89033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 809 S. Collington Ave 24 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fred Schaen .....

(a) Residence No. 1406 Webster St, ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-~~If married, widowed, or divorced~~ HUSBAND ~~of (or) WIFE of~~ Annie Schaen

6-DATE OF BIRTH (month, day and year) June 26, 1883

7-AGE. 41 yrs. 1 mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. Schaen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Teresa Imhoff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14- (Informant) Annie Schaen

(Address) 1406 Webster St

15- JUL 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 28, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1924 to July 28, 1924

that I last saw him alive on July 25, 1924

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Intestinal Toxemia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(Duration) ..... yrs. 8 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? C.S. & S.

(Signed) John J. Krauter M. D.

. 19 (Address) 2621 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill.	7-31 1924
20-UNDERTAKER.	**ADDRESS**
E & B Hale	115 E Hoffman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Steineman

D 89034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89034

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., Ward A) Registered No.

2-FULL NAME Esther Steineman

(a) Residence No. 761 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred not known yrs. mos. ds. How long in U. S., if of foreign birth? not yrs. known mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS:

10-NAME OF FATHER, Adolf Hausdorf

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant)

(Address) Hospital records

15- JUL 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29/24

17- I HEREBY CERTIFY, That I attended deceased from 7/17/24, 19..., to 7/29/24, 19...

that I last saw her alive on 7/29/24, 19...

and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

(1) Carcinoma Breast

enquired glands

(2) Cardiac disease

(Duration) x yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ira P. Chaney, M. D.

(Address) City View Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lenwo Rosedale Cem. DATE OF BURIAL. July 30 1924

20-UNDERTAKER. L Freiman Bro ADDRESS E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89035

CERTIFICATE OF DEATH.

D 89035

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 E. Preston St., 10 Ward) Registered No. 9

2-FULL NAME Catherine Campbell

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1007 E. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widow, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Peter Campbell Sr.

6-DATE OF BIRTH (month, day and year) Unknown 1834

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS:

10-NAME OF FATHER, Thomas Bennett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Grant

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14-Informant, Wm. M. Reinhardt

(Address) 1007 E. Preston St.

15. JUL 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 8th 1923 to July 28th 1924

that I last saw her alive on July 28th 1924

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer M. D

July 30th 1924 (Address) 705 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Mary's Cem. Govans

DATE OF BURIAL. July 31 1924

20-UNDERTAKER. Chas. F. Evans & Son

ADDRESS 118 N. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 89036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Mt Royal Av ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stein

(a) RESIDENCE No. 1315 Mt. Royal Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Gilly Stein

6 DATE OF BIRTH (month, day, and year) July 24 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Henry Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Dannenhoffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Henry Stein M. D.

(Address) 1315 Mt. Royal Av

15 Filed JUL 30 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to July 29, 1924,

that I last saw him alive on July 28, 1924,

and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Gener. Arterio Sclerosis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. 48 hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None -

(Signed) Carroll Lockard, M. D.

(Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 8/1-1924

20 UNDERTAKER Chas J. Krause & Son

ADDRESS 1180 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 89037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89037

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Uffington Rd ST.: Mt. Washington WARD)

2-FULL NAME Robt. P. Goddard

(a) RESIDENCE. NO. Uffington Rd ST., WARD. Baltimore, Kansas
(Usual place of abode) (If not in Baltimore give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Goddard

6 DATE OF BIRTH (month, day, and year) Aug 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chillicothe Mo

PARENTS

10 NAME OF FATHER Joseph Goddard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo

12 MAIDEN NAME OF MOTHER Lucretia Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Kate Goddard Olathe - Kansas

15 Filed Robert P. Harrison, Registrar

JUL 30 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1924

17 I HEREBY CERTIFY, that I attended deceased from July 26, 1924, to July 30, 1924, that I last saw him alive on July 28, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows: Arterio-sclerosis, with hypertension and cardiac decompression - Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute cardiac failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Harvey Cole, M. D.

7/30, 1924 (Address) 220 Dodson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kansas City - Kansas DATE OF BURIAL July 31 1924

20 UNDERTAKER Wm J Pickner & Sons ADDRESS Mottet & Pa

GwB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 N. Duncan St., 7 Ward) Registered No.

2-FULL NAME Joseph Holman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 711 N. Duncan St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Mulatto

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 1 1923

7-AGE. 1 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:

10-NAME OF FATHER, Andrew Holman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary Powell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-Informant Andrew Holman

(Address) 711 N. Duncan St

15-Filed JUL 30 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30/24

17-I HEREBY CERTIFY, That I attended deceased from July 24 24 to July 30 24

that I last saw him alive on July 30 1924

and that death occurred, on the date stated above, at 2P. m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumo

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

(Address) 801 N. Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL. July 31 1924

20-UNDERTAKER Fred Encklon ADDRESS 1716 Eutaw Pl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89039

D 89039

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 W Lombard ST., 19 WARD)

2-FULL NAME Mary A Rosendale

(a) RESIDENCE No. 1722 W Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rosendale

6 DATE OF BIRTH (month, day, and year) Oct 18 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	69	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry C Rosendale

(Address) 2062 Woodbourne St

JUL 30 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to July 28, 1924, that I last saw her alive on July 27, 1924, and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia

(duration) 2 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. A. Brill, M. D.

7/29, 1924 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/31 24
20 UNDERTAKER George A Tully Fulton	ADDRESS Fayette

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89040

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 89040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Lillian Mechlinsky

(a) Residence No. 601 S Monroe St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of (Oct 27 1924)

6-DATE OF BIRTH (month, day and year) 9 months

7-AGE. 9 months yrs. mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, James Mechlinsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do not know

12-MAIDEN NAME OF MOTHER, do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do not know

14-

(Informant) James Mechlinsky

(Address) 601 S Monroe St

15-

Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30 1924

17. I HEREBY CERTIFY, That I attended deceased from July 30th 1924 to July 30 1924, that I last saw h[illegible] alive on July 30th 1924, and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Idgs

(Signed) H. L. Harper M. D

19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL, 8/1, 1924

20-UNDERTAKER, Jno A Smith Fulton & Fayette

ADDRESS

AUG 1 1924

8—WRITE PLAINLY, WITH UNFADING INK—This ... should be carefully supplied. AGE should be stated ... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89041

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Welsh

(a) RESIDENCE NO. 2205 Hennemen ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bar Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records (Address)

15 Filed JUL 30 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-15, 1924, to 7-28, 1924, that I last saw him alive on 7-28, 1924, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Drew, M. D.

7-29, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	7/30 1924

20 UNDERTAKER George Ruth ADDRESS 1705 Harford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should s... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89042

CERTIFICATE OF DEATH.

57 D 89042

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Franklin Square Hospital ST., 40 WARD)

2-FULL NAME Francesco Raffo

(a) RESIDENCE NO. 1220 E. Madison ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~wife of~~ Theresa Gambartelli

6 DATE OF BIRTH (month, day, and year) Jan 23, 1861

7 AGE: Years 63; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit merchant

(b) General nature of industry, business, or establishment in which employed (or employer) (45

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Domenico Raffo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Scatamaglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Domenico Raffo (Address) 1220 E. Madison St

15 Filed JUL 30 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to July 28, 1924, that I last saw h[illegible] alive on July 28, 1924 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. about ds.

CONTRIBUTORY (Secondary) Chr Nephritis, osteomyelitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 19/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M.D.

(Address) 407 N. Eden St

July 30/24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 7/30 1924

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Av

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89043

CERTIFICATE OF DEATH.

90 D 89043

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 Falls Road St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J. Baker

(a) Residence No. 1102 Falls Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of W. H. Baker

6-DATE OF BIRTH (month, day and year) June 12, 1849

7-AGE, 75 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bryan Born

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Turnbaugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) W. H. Baker

(Address) 1102 Falls Road

15-

Filed JUL 30 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29-24

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to July 29, 1924

that I last saw h.....alive on July 29, 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis, Myocarditis Hypertensive

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) E. H. Krach, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Conn. DATE OF BURIAL, August 1, 1924

20-UNDERTAKER, E. LeRoy Stiffler ADDRESS 125 E. North Ave

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Milton Trostle

(a) RESIDENCE NO. Gettysburg Pa ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gettysburg

PARENTS

10 NAME OF FATHER John E Trostle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Alice Pister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 JUL 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to July 30, 1924.

that I last saw h[illegible] alive on July 30, 1924,

and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor -
Cerebellar-Brainstem
Locally Malignant -

[redacted] (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 30

Was there an autopsy? Yes Partial

What test confirmed diagnosis? Operation

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Pa — DATE OF BURIAL July 31 1924

20 UNDERTAKER Jas. H. Adams — ADDRESS 221 B Way

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89045

CERTIFICATE OF DEATH.

160 D 89045

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Poppleton ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allison Theodosia Ruff

(Residence in Baltimore: No. 411 Poppleton St.; ....yrs....mos....ds.)

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Infant

6-DATE OF BIRTH, 7 (Month) 16 (Day), 1924 (Year)

7-AGE, ...yrs....mos. 12 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, John Lewis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Georgeann Ruff

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgeann Ruff

(Address) 411 Poppleton St

15- JUL 31 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 29 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16th 1924, to July 29th 1924, that I saw him alive on July 29 1924, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jas. C. Carper M. D.

....., 191... (Address) 1063 Lexington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	7/31, 1924
20-UNDERTAKER David Earhart	ADDRESS 916 Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89046

CERTIFICATE OF DEATH.

46 D 89046

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 679 Bradley St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Julia Scott

(a) Residence No. 679 Bradley St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D Scott

6-DATE OF BIRTH (month, day and year) Mar 6 1874

7-AGE. 50 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Gloucester Co Va

PARENTS.

10-NAME OF FATHER, Ruben Whiteus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Gloucester Co Va

12-MAIDEN NAME OF MOTHER, Lucy Howard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Gloucester Co Va

14-Informant) Mrs Scott

(Address) 679 Bradley Ave

JUL 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 30, 1924

17. I HEREBY CERTIFY, That I attended deceased from April 15 19 24 to July 30 19 24

that I last saw her alive on July 29 19 24

and that death occurred, on the date stated above, at 5-10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. R. Coursey M. D.

, 19 (Address) 753 Hodges

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. 7/31 19 24

20-UNDERTAKER. Daniel Easton — ADDRESS 916 Pa. ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 39047

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 S 4th St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna K. Stiller

(a) Residence No. 103 S 4th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Stiller

6-DATE OF BIRTH (month, day and year) Aug 11-1861

7-AGE. 62 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Charles Stiller

(Address) 2440 Foster Ave

15- Filed JUL 31 1924 ROBERT N. KRAUTER, Burial Permit Officer. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 15 19 24 to July 29 19 24

that I last saw h... alive on July 29 19 24

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Colon Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Christian L. Radtke M. D.

7/30, 19 24 (Address) 3356 E. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery — DATE OF BURIAL. Aug 1 1924

20-UNDERTAKER. H. Sanders & Sons — ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89048

CERTIFICATE OF DEATH.

188-D 89048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad R. Liersemann

(a) RESIDENCE No 260 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Feb 7/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	32	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Press-hand
(b) General nature of industry, business, or establishment in which employed (or employer): Can-maker
(c) Name of employer: Continential Can. Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Adolph Liersemann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Alvina Oldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Liersemann
(Address): ~~260 S. East Ave~~

15 Filed JUL 31 1924 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture neck & broken neck
(Motorcycle accident, inquest to held July 30/24)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Wallace, M. D.
(Coroner.)

7/30/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 31 1924
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Hovermale

D 89049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 89049

1-PLACE OF DEATH

City of BALTIMORE: (No. 1578 N. Fulton Ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Generen E. Hovermale

(a) Residence No. 1578 N. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 9-1907

7-AGE, 16 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Geo W. Hovermale

11-BIRTHPLACE OF FATHER (city or town) (State or Country): W. Va.

12-MAIDEN NAME OF MOTHER: Susie E. Hovermale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): W. Va.

14- (Informant) Geo W. Hovermale

(Address) 1578 N. Fulton Ave

15-

Filed....., 192.. ROBERT R. KRAUTER, Registrar.

JUL 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29/1924

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to July 29, 1924, that I last saw her alive on July 29, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Patrick M. D.

7/29 1924 (Address) 4362 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Woodlawn Cem	Aug 1, 1924
20-UNDERTAKER,	ADDRESS
Harry W. Eblen	W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Eccleston, 1027 E Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89050

CERTIFICATE OF DEATH.

8 128

D 89050

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1837 N. Durham St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn May Lancarrow

(a) Residence No. 1837 N. Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W

5-Single, Married, Widow(er) or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 30, 1920

7-AGE. 4 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER Walter O Lancarrow

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Va.

12-MAIDEN NAME OF MOTHER Eva M Silk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md.

14- (Informant) Mrs Walter Lancarrow

(Address) 1837 N Durham St

15- Filed JUL 31 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25 1924 to July 30 1924

that I last saw h[illegible] alive on July 29 1924

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) 3 mos. 5 ds.

CONTRIBUTORY (Secondary) Uraemia + Convulsions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Alabama

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Robert Krauter, M. D.

7/30 1924 (Address) 2027 East Fifth Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL, Aug. 1924

20-UNDERTAKER, Wm. Cook — ADDRESS 522 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated E... In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8905I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8905I

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 E North Ave ST.) 12 WARD)

REGISTERED NO. C 71-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Abram Martin Smith

(Residence in Baltimore: No. 337 E North Ave St.; 70 yrs., 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct (Month) 16 (Day), 1850 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 10 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired R R 073
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer U. S. A.

9-BIRTHPLACE, (State or Country), Newport, Perry Co, Penna

PARENTS.

10-NAME OF FATHER, Henry D. Smith

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Eliza Harding

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie G. Smith

(Address) 337 E North Ave.

15- Filed JUL 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1924, to July 30 1924, that I saw him alive on July 29 1924, and that death occurred, on the date stated above, at 5.19 m.

The CAUSE OF DEATH* was as follows:

Meningeal Gastro-enteritis

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Convulsion

(Duration) yrs. mos. ds.

(Signed) Dwight Forsyth M. D.

July 31, 1924. (Address) 424 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Aug. 2, 1924

20-UNDERTAKER H. M. Cook ADDRESS 502 E Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89052

100-001

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3515 Old Jut Rd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Virginia E. Mills

(a) Residence No. 3515 Old Jut Rd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 17/23

7-AGE, ...yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... School Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles E Mills

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Eastern Shore Md

12-MAIDEN NAME OF MOTHER, Marguerite E Parker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Mrs C E Mills

(Address) 3515 Old Jut Rd

15- Filed JUL 31 1924, 192 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30/24

17- I HEREBY CERTIFY, That I attended deceased from July 28th 1924, to July 30th 1924

that I last saw h.r alive on July 28th 1924,

and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Resp Exam

(Signed) C. Livingston Mallin M. D.

July 30, 1924 (Address) 1017 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL, Aug 1 1924

20-UNDERTAKER. Gudgeon Bros & Krautter — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89053

CERTIFICATE OF DEATH.

139

D 89053

1-PLACE OF DEATH West Baltimore General Hospital

REGISTERED NO. D 89053

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Baily

(a) RESIDENCE NO. 615 N. Paca ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Baily.

6 DATE OF BIRTH (month, day, and year) 7/14 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Jamestown Va.

PARENTS

10 NAME OF FATHER George Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. Baily (Address) 615 N. Paca St.

15 Filed JUL 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to July 28, 1924, that I last saw her alive on July 28, 1924, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Myoma Uteri

(duration) Indefinite yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) 6 hrs. yrs. ..... mos. .....

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 25-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Opinion.

(Signed) James Hubert Ukerson M. D.

19 (Address) West Balto. San. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 7/31 1924

20 UNDERTAKER Samuel Schneider

ADDRESS 678 Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Baltimore, Md., August 11, 1924.

This is to certify that there personally appeared
efore me this 11th day of August, 1924, William Finnie,
ho made oath to the following statements.

That he is the son-in-law of the person whose death
recorded on Baltimore City Health Department Certificate
Death D-89053, date of death July 28, 1924; that he
as present at the funeral of said party and identified
he body of said person; and that the correct name of
aid party was Lucy F. Brumskin and should be so recorded
n the Death Certificate, instead of Lucy Baily, as now
ppears on said certificate.

William Finnie

Notary Public.

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Automobile factory.
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Statement of Caus
DISEASE CAUSING DEATH (the primary affection with
respect to time and causation), using always the
same accepted term for the same disease. Examples:
Cerebrospinal fever (the only definite synonym is
"Epidemic cerebrospinal meningitis"); *Diphtheria*
(avoid use of "Croup"); *Typhoid fever* (never re-
port "Typhoid pneumonia"); *Lobar pneumonia;*
Bronchopneumonia ("Pneumonia," unqualified, is
indefinite); *Tuberculosis of lungs, meninges, peri-*
toneum, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89054

CERTIFICATE OF DEATH.

185 D 89054

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Ford. (C).

(a) RESIDENCE NO 2306 Etting St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~the late~~ Bertha E. Ford. (C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer) Lafayette Mill &
(c) Name of employer Lumber Co.

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER James E. Ford. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Agnes Brown. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Bertha E. Ford. (C)(wife). (Address) 2306 Etting Street.

15 Filed JUL 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of skull and spine.
Accidental fall from a lumber loft.

(duration) -- yrs. -- mos 2 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 30, 1924 Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Lafayette Mill & Lumber Co. Lafayette Ave &

Former or usual residence Pulaski St. July 28, 1924

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL July 31 1924

20 UNDERTAKER Joseph A. Farrell ADDRESS 2319 Guil...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89055 114 D 89055

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1810 N. Gay St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Louis A. Ege

(a) Residence No. 1810 N. Gay St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? 41 yrs. 6 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Ege

6-DATE OF BIRTH (month, day and year) Dec 31st 1882

7-AGE, 41 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, John Ege

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), City

12-MAIDEN NAME OF MOTHER, Rosa Frankberger

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), City

14- (Informant) Mrs. John Ege

(Address) 1310 N. Gay St.

15- Filed JUL 31 1924 ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 2 1924 to July 29 1924

that I last saw h. alive on July 28 1924

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion + Heat

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7/30/1924 (Address) 125 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Aug. 1st 1924

20-UNDERTAKER, Peter Nicolaus 2060 — ADDRESS Eastern Ave

CITY OF BALTIMORE
MARYLAND

MUNICIPAL DEPARTMENTS

HEALTH DEPARTMENT

EXECUTIVE OFFICE

C. HAMPSON JONES, M. D.
COMMISSIONER AND REGISTRAR, V. S.

J. FREDERICK HEMPEL, M. D.
ASSISTANT COMMISSIONER

REED GAITHER,
SECRETARY

AUG 9 - 1924

August 7, 1924.

Dr. Frank C. Bresslor,
125 S. Broadway,
Baltimore, Maryland.

Dear Dr. Bresser:

We have received the death certificate of Louis H. Ege, who formerly lived at 1810 N. Gay Street, on which you gave as the cause of death "Gastro-Enteritis". From information that has been brought to me there seems to be a possible connection between the use of an acetylene torch, with a possible leakage in the hole of the vessel, and the disease from which he died.

I shall be much pleased if you will let me hear from you.

Respectfully yours,

C. Hampson Jones
Commissioner of Health.

G.

No connection whatever between Cause of Death & Acetylene poisoning. This has been traced out from every angle, but results were not those of above mentioned condition, but were given due consideration, Eliminated.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89056

CERTIFICATE OF DEATH.

181 D 89056

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Eye, Ear & Throat Hosp. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn May Alston

(a) RESIDENCE No. 1036 Warden Ave ST., WARD Pikesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 28 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Harvey L. Alston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Ogden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant H. L. Alston (Address) 1036 Warden Ave.

15 Filed JUL 31 1924 ROBERT F. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ether Anaesthesia (accidental & unavoidable)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Operation for removal of tonsils. (duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery Calvert Co. Md

DATE OF BURIAL Aug. 1 1924

20 UNDERTAKER Henry Horch Son

ADDRESS 1309 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89057

CERTIFICATE OF DEATH.

44 D 89057

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Woodbourne Ave Govans ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryann Warrener

(a) RESIDENCE NO. 500 Woodbourne Ave Govans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Edward Warrener

6 DATE OF BIRTH (month, day, and year) March 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Mar 1, 1855	69		30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lincolnshire England

PARENTS

10 NAME OF FATHER Thomas Howes

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Miss Clara Snyder

Address 500 Woodbourne Ave. Govans

JUL 31 1924

Filed ..... 19 ..... ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1924

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1924, to July 30, 1924, that I last saw h[illegible] alive on July 30, 1924, and that death occurred, on the date stated above, at 6:00 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

Generalized Carcinomatosis of viscera

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dementia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. K. Bishop, M. D.

July 31 19 24 (Address) 501 Sheffield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cem., Glencoe, Md.	Aug. 2 1924
20 UNDERTAKER	ADDRESS
Wm. C. Brooks	Sparks, Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1935-97

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89058 CERTIFICATE OF DEATH.

38 D 89058

REGISTERED NO.

1-PLACE OF DEATH MERS MORRIS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Mr. Wolfe Cohen

(a) RESIDENCE NO. 1625 E. Baltimore St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Cohen

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 31 1924 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to July 30, 1924, that I last saw him alive on July 30, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Cortitis

Chronic Nephritis

(duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Cot home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. R. Harmon M. D.

7/31, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL July 31 1924

20 UNDERTAKER Fast Kemp, 1439 E. Balto ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89059

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-981 89059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Evergreen Ave (Hamilton) 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Bareford

(a) RESIDENCE No. 34 Evergreen Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W.A.Bareford

6 DATE OF BIRTH (month, day, and year) Nov 29/1950

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Charles Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co.Md.

12 MAIDEN NAME OF MOTHER Elizabeth unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Chas. A. Bareford
(Address) 709 W. Pratt St

15 Filed JUL 31 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) S. H. Evans, M. D.
(Coroner.)

7/30/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem. Baltimore	Aug 1, 1924
20 UNDERTAKER A Howard Evans Co. Balto Md	ADDRESS 38 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89060

CERTIFICATE OF DEATH.

203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Kemp

(a) RESIDENCE No. 315 E. 21 1/2 St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Kemp

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Easton (Undertaker)
(Address) 916 Penna Ave

15 JUL 31 1924 193 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis-peritonitis
(Infection thru uterus-possible traumatism-autopsy at Hospital)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (over)
(duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Collins, M. D.
(Coroner.)

7/31/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gloster Point, Va.	July 31/1924
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 89061

CERTIFICATE OF DEATH

118-002

B 89061

1-PLACE OF DEATH 162 Argyle Ave

CITY OF BALTIMORE: (No. Balto St.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli Ball

(a) RESIDENCE. NO. 162 Argyle ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie Ball

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 31 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: H. Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Katie Ball

(Address) 162 Argyle ave

15 Filed . 19 Registrar

ROBERT R. KRAUSER, Burial Permit Clerk.

JUL 31 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-30-1924

17

I HEREBY CERTIFY, That I attended deceased from 7-26-, 1924 to 7-30-, 1924

that I last saw h[illegible] alive on 7-30-, 1924

and that death occurred, on the date stated above, at 9.30 A m. 9.35 a m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Bilateral ss

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 162 Argyle

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Boykin, M. D.

, 19 (Address) 1618 Caldon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 8-1 1924

20 UNDERTAKER: Geo. J. A. Gelon — ADDRESS: 1735 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89062

CERTIFICATE OF DEATH.

90 D 89062

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Ashland Ave. St.) 7 WARD)

2-FULL NAME Hariet Amy Baker

(a) RESIDENCE NO. 1738 Ashland Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John W. York

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: John Cephus

(Address): 1738 Ashland Ave.

15 Filed JUL 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924 to July 27, 1924.

that I last saw her alive on July 27, 1924.

and that death occurred, on the date stated above, at 4:25 p m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardio-vascular disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Robinson M. D.

(Address) 1522 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	July 31 1924

20 UNDERTAKER: Mrs. A. E. Elliott ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89063

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 21 WARD)

2-FULL NAME William Parsons

(a) RESIDENCE. No. 516 Carroll ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54yr yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records

(Address)

FILED JUL 31 1924 ROBERT R. KRAUTER, Registrar

1651 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-22, 1924, to 7-28, 1924

that I last saw him alive on 7-28, 1924

and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial degeneration

(duration) yrs. 8 mos. (Estimated) ds.

CONTRIBUTORY .....

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Dorr, M. D.

7-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER Commissioner Health.	ADDRESS JUL 31 1924
Per. Wm. E. Woodall	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

285

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89064
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15 47

D 39064
Registered No.

City of BALTIMORE: (No. 1730 Ashburton St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Louisa Phillips

(a) Residence No. 1730 Ashburton St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~ Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Phillips

6-DATE OF BIRTH (month, day and year) May 30th, 1886

7-AGE. 36 yrs. 1 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

037

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Thomas S. Keen

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Margaret J. Reese

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14-
(Informant) Mrs Margaret J. Keene
(Address) 1730 Ashburton St

15-
Filed ..... 192.....
JUL 31 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29th, 1924

(1) I HEREBY CERTIFY, That I attended deceased from June 30th, 19 24 to July 29, 19 24
that I last saw her alive on July 29, 19 24
and that death occurred, on the date stated above, at 7.55 P.m.

The CAUSE OF DEATH* was as follows:
Intestate Carcinoma, (Primary in breast.)
Involving Lumbar spine, Viscera.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. McAleary, M. D.
7/31, 1924 (Address) 408 W Fayette

State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery
DATE OF BURIAL: Aug 1st, 24

20-UNDERTAKER: per Bertram Lowe
ADDRESS 1723 W Fay ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89065

CERTIFICATE OF DEATH.

128

D 89065

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1216 Homewood St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Strohmeyer

(a) Residence No. 1216 Homewood St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 9, 1884

7-AGE. 39 yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Linestype operator

(b) General nature of industry, business, or establishment in which employed (or employer). The Sun

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Eugene Strohmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Rosina Merritt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14-(Informant) Eugene Strohmeyer

(Address) 1216 Homewood

JUL 31 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to July 31, 1924, that I last saw h.. alive on July 31, 1924, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) [illegible], M. D.

7/31/24 (Address) 704 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER. Jenkler & Jenkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

89066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46D 89066

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Youngkouse

(a) Residence No. 1020 W. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. George Krauter

(Address) 176 S. Washington St.

15- Filed JUL 31 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29th 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 22 1924 to July 29 1924 that I last saw h.. alive on July 29 1924 and that death occurred, on the date stated above, at 9:00 P. M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma (uterine) cervix ?

(Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Hdqrs. Lab

(Signed) H W Harbert, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Aug. 1, 1924
20-UNDERTAKER. Lilly and Zeih	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89067

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D 89067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 Lemmon St. 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Edward Snyder

(a) Residence No. 1801 Lemmon St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 21 24

7-AGE. ..... yrs. 10 mos. ..... ds.

If LESS than 1 day .... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Lindsay Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Minnie Mellet

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md.

14-

(Informant) Lindsay Snyder

(Address) 1801 Lemmon St.

15-

Filed ..... Robert P. Harrison, Registrar.

FL 3 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30 '24

17- I HEREBY CERTIFY, That I attended deceased from July 29 19 24 to July 30 19 24

that I last saw him alive on July 30 19 24

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) Jas. H. Lingenfelter M. D.

7/31 1924 (Address) 1729 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Loudon Park Cemetery	July 31 24
20-UNDERTAKER	ADDRESS
F. B. Hepfert	2256 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89068

D 89068

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Public School

CITY OF BALTIMORE: (No. 4th, & Potomac Sts. Brooklyn St., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin. Reinhardt.

(a) RESIDENCE No. 7 South 4th, St. Brooklyn St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Maggie Reinhardt.

6 DATE OF BIRTH (month, day, and year) August 18, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Public School
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER Frederick Reinhardt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Schmidt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Maggie Reinhardt. (wife).
(Address) 7 South 4th, St. Brooklyn.

15 Filed JUL 31 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 192 4.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

July 31. 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: Aug 2 192 4

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

AGE should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89069

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Penna Ave. ST.; 17 WARD)

2-FULL NAME Maggie Johnson

(a) RESIDENCE No. 1031 Penna Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1879 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

870

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant William Walker
(Address) 1031 Penna ave.

15 Filed JUL 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

July 31, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem

DATE OF BURIAL 8/1/24

20 UNDERTAKER David Earley

ADDRESS 916 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89070

CERTIFICATE OF DEATH.

91-800 D 89070

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1506 Division ST., 14 WARD)

2-FULL NAME Rachell Campbell

(a) RESIDENCE NO. 1506 Division ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Along Campbell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Anne Arundel

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Theresa Richardson
(Address) 1506 Division St

JUL 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28th 1924 to July 30th 1924

that I last saw he alive on July 29th 1924

and that death occurred, on the date stated above, at 3.50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Jay Ellis, M. D.

(Address) 1506 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 8/1/24

20 UNDERTAKER David Easton

ADDRESS Balto

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89071

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 89071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3121 Eastern Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Meyers

(a) Residence No. 3121 Eastern Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E Meyers

6-DATE OF BIRTH (month, day and year) Jan. 9 1844

7-AGE, 80 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Meyers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Wells

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Howard Meyers

(Address) 3121 Eastern Ave

15- Filed JUL 31 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30/1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 24 to July 30 1924, that I last saw h alive on July 30 1924, and that death occurred, on the date stated above, at 8 40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart: Mitral Regulation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H K M Jouett M. D.

July 31 1924 (Address) 2938 E. Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem — DATE OF BURIAL, Aug 2 1924

20-UNDERTAKER, John Ulrich — ADDRESS 2088 Orleans

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89972

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-083 D 89972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R. Russell Mister

(a) RESIDENCE No. 402 N. Rose St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freda Mister

6 DATE OF BIRTH (month, day, and year) May 9/ 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Can-maker
(b) General nature of industry, business, or establishment in which employed (or employer) Continental Can Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER Edgar C. Mister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md

12 MAIDEN NAME OF MOTHER Bertha M. Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant Edgar C.Mister
(Address) 402N. Rose St

15 Filed JUL 31 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured skull-accidental-fell from rear of autotruck

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Owens, M. D. (Coroner)

7/31/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem — DATE OF BURIAL Aug/ 1924

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN old state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89073

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary ST. 24 WARD)

2-FULL NAME Anthony A. Shepke

(a) RESIDENCE No 1410 Reynolds ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 28, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer): 031
(c) Name of employer: Tin Decorating Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph Shepke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Lucille Melthowak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Europe

14 Informant: Alex. Shepke (Bro)
(Address): 1410 Reynolds St

15 Filed JUL 31 1924, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30/24 192..

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed skull-accidental-caught in closing sky-light

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Watts (Coroner.), M. D.

7/31/24 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Lot	Aug 2 192 4
20 UNDERTAKER: Margaret E. Flynn	ADDRESS: 1402 Light St

AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation CUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89074

CERTIFICATE OF DEATH.

118 D 89074

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., 12 WARD)

2-FULL NAME Rose Moore

(a) RESIDENCE NO. 1725 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael J. Moore

6 DATE OF BIRTH (month, day, and year) May 16, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant James Moore
(Address) 1725 Barclay St

15 JUL 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to July 30, 1924.

that I last saw her alive on July 30, 1924,

and that death occurred, on the date stated above, at 5 1/2 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.
Toxaemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Strangulated umbilical hernia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1725 Barclay St

Did an operation precede death? Yes Date of 7/28/24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Lyle M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Jos. Cem. Relay Md.

DATE OF BURIAL Augr 1924

20 UNDERTAKER Margaret F. Flynn

ADDRESS 1111 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89075

CERTIFICATE OF DEATH.

101-001

D 89075

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Antonine Jacobs

(a) Residence No. 709 Redwood St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) 1880

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Peter Jacobs

(Address) 709 W. Redmond St

AUG 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/30/24

17- I HEREBY CERTIFY, That I attended deceased from July 17th 19 4 to July 30th 19 24

that I last saw her alive on July 30th 19 24

and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Post Operative pneumonia

(Lobar)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) operation for myoma of uterus (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/23/24

Was there an autopsy? no

What test confirmed diagnosis? Lab & phys Dgs

(Signed) H W Harper M. D

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER. Chas. B. Kuchondo — ADDRESS 637 Pacca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

Austin McLaughlin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89076

CERTIFICATE OF DEATH.

13

D 39076

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital Southend Queens WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME McLaughlin Austin

(a) RESIDENCE NO. Mt Olivet Cem. (in Mt Olivet Cemetery) ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4, 1924

7 AGE	Months	Days	If LESS than 1 day, ... hrs. or .... min.
~~Yrs~~ 5 months	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Austin McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Bertie Brashear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew J Brashear

(Address) 1932 Hollins St

15 Filed AUG 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to July 31, 1924.

that I last saw him alive on July 30 1924,

and that death occurred, on the date stated above, at 1:10 a.m.

The CAUSE OF DEATH* was as follows:

Tentorial Toxemia

One week (duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony J Bruchas M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 1 1924
20 UNDERTAKER George E Smith	ADDRESS 1534 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

LANGLEY

D 89077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

B 89077

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Sarah Ann St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Henrietta Langley

(a) Residence No..... 908 Sarah Ann St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feby 26 1859

7-AGE, 64 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)..... Do

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. William J. Morgan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lynchburg Va

12-MAIDEN NAME OF MOTHER. Georgeanne Hunt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Annapolis Md

11- (Informant) Isabella Johnson

(Address)..... 908 Sarah Ann st

AUG 1 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH. 1924

16-DATE OF DEATH (month, day and year). May 26

17- I HEREBY CERTIFY, That I attended deceased from July 24, 19 24, to July 28, 19 24,

that I last saw h.. alive on July 28, 19 24,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Clinical Exam.

(Signed) Wm E. Batson M. D.

7/31, 1924 (Address) 106 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Aug 1st 1924

20-UNDERTAKER. A Jones ADDRESS. 111 S. Gilmor St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 89978

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-03 89978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 S. Paca ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby May Moon

(a) RESIDENCE. No. 1035 S. Paca ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
		5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Moon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Good

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mr. John Moon 1035 S. Paca St

15 Filed AUG 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 30, 1924, that I last saw her alive on July 30, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchites

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. Edward Norris, M. D.

7 30 24 (Address) 107 E. west St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cath. Cem. Cov	Aug 1 1924
20 UNDERTAKER Tolle & Cowan & Son	ADDRESS
Per J. J. Cowan	90 Holliday

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89079

CERTIFICATE OF DEATH.

D 89079

Registered No. 88

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 Hilton St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie V. Ebrly.

(a) Residence No. 1701 Hilton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edw'd Ebrly

6-DATE OF BIRTH (month, day and year) Mch 24 1859

7-AGE 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country) W. Virginia

PARENTS.

10-NAME OF FATHER Solomon Van Meter

11-BIRTHPLACE OF FATHER (city or town) (State or Country) W. Virginia

12-MAIDEN NAME OF MOTHER, M Cox

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14- (Informant) Edw'd Ebrly

(Address) 1701 Hilton St

15- AUG 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31 1924

I HEREBY CERTIFY, That I attended deceased from July 30 1924 to July 31 1924

that I last saw her alive on July 30 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Arthritis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Robert Evans M. D.

19 (Address) 701 N. Carey

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, June 7, 1924

20-UNDERTAKER, John A. Mitchell ADDRESS 1911 W. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89080

CERTIFICATE OF DEATH.

44

D 89080

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1622 N. Calvert St., IV Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary W. Hays

(a) Residence No. 1622 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thompsell Hays

6-DATE OF BIRTH (month, day and year) Nov. 27 1853

7-AGE.	If LESS than 1 day.
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Harford Co Md

PARENTS.

10-NAME OF FATHER. Edw A Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Harford Co Md

12-MAIDEN NAME OF MOTHER. Sallie E. Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Harford Co Md

14-

(Informant) Thomas A Hays

(Address) 1622 N. Calvert St

15-

AUG 1 - 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/30/24

17- I HEREBY CERTIFY, That I attended deceased from April, 1924, to 7/30, 1924

that I last saw h[illegible] alive on 7/30 1924

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Obstruction of bowels

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 26/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Edw A Abbott M. D.

7/31 1924 (Address) 1403 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rock Spring Cem Harford Co Md DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 1211 Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89081

CERTIFICATE OF DEATH.

B 89081

REGISTERED NO.

1-PLACE OF DEATH South Balto. Gene. Hospital

CITY OF BALTIMORE: (No. 1213 Light St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Daniel Fisher

(a) RESIDENCE NO. 23 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work in fancy goods

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Phillip J. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Edna George

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant Mrs Edna Fisher

(Address) 23 W Hill St.

AUG 1 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to July 31, 1924, that I last saw him alive on July 31, 1924, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) J. E. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Aug 1 1924

20 UNDERTAKER E. Schlosman & Son ADDRESS 1937 Hanover St

Spec– 12-23-21– E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89082

CERTIFICATE OF DEATH.

91-002 D 39082

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 1811 W North Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Burger

(a) Residence No. 1811 W North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of Mary Burger

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-(Informant) Mary Burger

(Address) 1811 W. North Ave.

AUG 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31- 24

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to July 31 1924

that I last saw h... alive on July 31 1924

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leetz M. D

7/31 1924 (Address) 2040 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross.	Aug 2, 1924
20-UNDERTAKER.	ADDRESS
W Fahey & Son	827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89083

CERTIFICATE OF DEATH.

X 118-002 D 89083

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Orrin Eddy.

(a) RESIDENCE No Catonsville, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -------.

6 DATE OF BIRTH (month, day, and year) February 12, 1915.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	9	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N.Y.

PARENTS

10 NAME OF FATHER Albert O. Eddy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Mabel Watley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Albert O Eddy. (father).
(Address) Knoxville Tenn. P.O.938

15 Filed AUG 1 192 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 192 4.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intussusception.
Oedema of the lungs.
Broncho-pneumonia.

(duration) -- yrs. -- mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Leonhardt, M. D.
(Coroner.)

July 31, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death? Catonsville Md. July 26, 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 2 192"

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Henry Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89084

99-002

CERTIFICATE OF DEATH.

D 89084

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Henry Smith St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Little Sister of the Poor

(a) Residence No..... Preston & Valley Sts. St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 4 March 1848

7-AGE, 76 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Benj. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Helen Shipley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Sister Superior

(Address) Preston & Valley Sts

15-

Filed ..... 192.. ROBERT P. KRAUTER

AUG 1 - 1924 Registrar of Burial Permits

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31/24

17- I HEREBY CERTIFY, That I attended deceased from Record ....., 19....., to ....., 19.....,

that I last saw h... alive on July 27, 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Contributory (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

July 31, 1924 (Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Aug. 1, 1924

20-UNDERTAKER, W. C. Wedefield — ADDRESS 914 Fremont Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89085

CERTIFICATE OF DEATH.

47 D 89085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Druid Hill Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Bentley

(a) RESIDENCE No. 1010 Druid Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander Bentley

6 DATE OF BIRTH (month, day, and year): Dec. 22- 1885

7 AGE: Years 49 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Isaac Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Florence Boswell (Address) 1009 Druid Hill Ave

15 Filed AUG 1 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1924

17 I HEREBY CERTIFY, That I attended deceased from July 21 1924, to July 29 1924,

that I last saw her alive on July 28 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Nephritis

(duration) 1 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Aug 1 1924

DATE OF BURIAL

20 UNDERTAKER: Samuel T. Wesley

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Turton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89086

CERTIFICATE OF DEATH.

38 D 89086

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Turton

(a) RESIDENCE. No. 423 Druid Hill ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Laborer~~

(b) General nature of industry, business, or establishment in which employed (or employer) Pianist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Turton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs Mable Young (Address) 36 N 112 St Apt Md Ref.

15 Filed . 19

AUG 1 - 1924

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-9, 1924, to 7-30, 1924, that I last saw him alive on 7-29, 1924, and that death occurred, on the date stated above, at 12:45 a. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis; Aortic Insufficiency; Myocardial Insufficiency; Left Hemiplegia (Thrombotic) (duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude D. Drace, M. D.

7-30. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 2nd 1924

20 UNDERTAKER Samuel F. Sweeney

ADDRESS 678 N Bradford St

Spec.—1-10-21—M&T—1500 Bks.

D 89087

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 89087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732-Waseche ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Field

(a) RESIDENCE NO. 732-Waseche ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Benjamin Field

6 DATE OF BIRTH (month, day, and year): 8-20-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Columbia S.C.

PARENTS

10 NAME OF FATHER: Joshua Blocker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Columbia S.C.

12 MAIDEN NAME OF MOTHER: Martha Blocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Columbia S.C.

14 Informant: Benjamin Field

(Address): 732 Waseche St

15 Filed AUG 1 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-31-1924

17 I HEREBY CERTIFY, That I attended deceased from 4/26, 1924, to 7/31, 1924, that I last saw her alive on 7/31, 1924, and that death occurred, on the date stated above, at 2:20 p m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

about

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Johns Hopkins

What test confirmed diagnosis? Microscopic Exploratory Laparotomy

(Signed) L. L. Gaglon M. D.

(Address) 806 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: Aug 2 25

20 UNDERTAKER: Samuel Hruska & Bro ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89088

CERTIFICATE OF DEATH.

112

D 89088

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3326 Gwynn Falls Pkwy Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benj R. Johnson

(a) Residence No. 3326 Gwynn Falls Parkway St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Almira E Hush

6-DATE OF BIRTH (month, day and year) Sept 25th 1865

7-AGE. 58 yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Ind

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Va

14- (Informant) Mrs Almira E Johnson

(Address) 3326 Gwynn Falls Parkway

AUG 1 - 1924

(Date) ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30 1924, to July 31, 1924, that I last saw h[im] alive on July 30, 1924, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

acute indigestion

(Duration) .....yrs. .....mos. 1/2 ds.

CONTRIBUTORY (Secondary).....

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? physical examination and symptoms.

(Signed) J. F. Chenoweth, M. D.

Aug. 1, 1924 (Address) 2226 Madison Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER. John G. Gowan & Son Chas G. J. Gowan

ADDRESS 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89089

CERTIFICATE OF DEATH.

X90 D 89089

Registered No.

1-PLACE OF DEATH

City of BALTIMORE (No. 907 Warner St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Diggs

(a) Residence No. 907 Warner St., 22 Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Col.

5-~~Single~~, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Drucilla Diggs

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Geo Diggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12-MAIDEN NAME OF MOTHER, Rosa Jordan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. C.

14-(Informant) Drucilla Diggs

(Address) 907 Warner St

15-Filed AUG 1 - 1924 19.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/29/24

17- I HEREBY CERTIFY, That I attended deceased from 7/7/24, 19.. to 7/29/24, 19.. that I last saw h.. alive on 7/28/24, 19.. and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute Parenchymatous Nephritis (Duration) 2m yrs. 2d mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jonathan Ley M. D.

8/1, 19 24 (Address) 908 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn DATE OF BURIAL, Aug 1, 1924

20-UNDERTAKER, John H. Toadvine ADDRESS 1412 Division St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17B 478 89090

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 89090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Badan

(a) RESIDENCE NO. 805 Dallas St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 7yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): July 16, 1924

7 AGE — Years — Months 7 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town) ? (State or country)
12 MAIDEN NAME OF MOTHER Sarah ?
13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 1 - 1924 Registered ROBERT R. KRAUTER
1652 Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to July 23, 1924, that I last saw her alive on July 23, 1924, and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:
Prematurity

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas R Bagg, M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: July 31 1924

20 UNDERTAKER: Commissioner of Health. — ADDRESS

For, Wm. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89091

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 619 N. Decker Ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Minnie C. Shintop

(a) Residence No. 619 N. Decker Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 14 - 1900

7-AGE, 24 yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Herman Shintop

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Adline Goldbrught

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) South Carolina

14- (Informant) Herman Shintop

(Address) 619 N. Decker Ave

15- AUG 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30, 1924

I HEREBY CERTIFY, That I attended deceased from June 26, 1924, to July 30, 1924, that I last saw h.r. alive on July 30, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Peck M. D.

7/31, 1924 (Address) 936 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL, Aug 1, 1924

20-UNDERTAKER, Jas E. Butler ADDRESS 2334 Jeffries

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See letter in file Dec 7-1925)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89092

CERTIFICATE OF DEATH.

74-001 ✓ D 89092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 N Calvert ST., 17 WARD)

2-FULL NAME Eliza P. Preston

(a) RESIDENCE NO. 1700 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowe

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John F Preston

6 DATE OF BIRTH (month, day, and year) August 12th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Thomas

11 BIRTHPLACE OF FATHER (city or town) Harford (State or country) Co Md

12 MAIDEN NAME OF MOTHER Eliza Thomas

13 BIRTHPLACE OF MOTHER (city or town) Harford (State or country) Co Md.

14 Informant Miss Ellen Frances Preston (Address) 1700 N Calvert St

15 Filed AUG 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13th 1924 to July 31st 1924

that I last saw her alive on July 31st 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coleness,

(Partial Hemiplegia for about 2 yrs: with recurring attacks of aphasia)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. F. Lockwood M.D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	August 2nd 1924
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Son Co	Orchard & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89093

89093

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Parker

(a) RESIDENCE. NO. 606 W. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denver, Col.

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Municipal Hospital Records (Address) UNIV

15 [illegible] -1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-8, 1924, to 7-28, 1924

that I last saw him alive on 7-28, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis
Aortic Insufficiency
Myocardial degeneration

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Left

(Signed) Claude B. Kraus, M. D.

7-28 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	AUG 1 1924
20 UNDERTAKER ADDRESS	
Commissioner Health,	

For Wm. E. Woodall

MARGIN RESERVED FOR INDEXING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 1

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N. Ellwood ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. McNeill

(a) Residence No. 503 N. Ellwood St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. McNeill

6-DATE OF BIRTH (month, day and year) Aug. 20 1853

7-AGE. 70 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Owen McNeill

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bondina Kensel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. McNeill (Wife)

(Address) 503 N. Ellwood ave.

15- Robert P. Harrison,

Filed AUG 1 1924 192.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 25 19 24 to July 30 19 24

that I last saw h— alive on July 30 19 24

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria

(Signed) John H. Ogburn M. D.

19 (Address) 35 N. Potomac St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. new Cathedral

DATE OF BURIAL. Aug. 2, 1924

20-UNDERTAKER. John A. Moran

ADDRESS 300 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89095

CERTIFICATE OF DEATH.

D 89095

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 126 WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannetta Levin

(a) RESIDENCE No. 23 Pine Heights Ave ST., WARD —

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 5 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Levin

6 DATE OF BIRTH (month, day, and year) July 14, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa

PARENTS

10 NAME OF FATHER—Leon Bamberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alsace Lorraine Europe

12 MAIDEN NAME OF MOTHER Henrietta Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria Germany.

14 Informant Miss Hattie Levin

(Address) 23 Pine Heights Ave.

15 Filed AUG 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Aug 1, 1924, that I last saw her alive on Aug. 1, 1924, and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder, with Metastases to Head & Pancreas & Liver

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 3, 1924

Was there an autopsy? No

What test confirmed diagnosis? Path. Examination of specimen taken at operation.

(Signed) Anthony V. Bruchanyi, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa.	8/3/1924
20 UNDERTAKER David Sandheim	ADDRESS 118 W. Mt Royal Ave

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89096 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89096

CERTIFICATE OF DEATH.

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Mrs. Regina Lowenstein

(a) RESIDENCE NO. Hebrew Hospital, E. Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lipman Lowenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Sonnenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Records
(Address) Robert F. Harrison,

AUG 1 1924 Filed ..... 19 ..... Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to July 31, 1924.

that I last saw her alive on July 31, 1924.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows

Angina Pectoris ?

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidor L. Fry M. D.

1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 8/3/1924

20 UNDERTAKER David Sondheim ADDRESS 1720 Mt. Royal Ave

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21—E.B.R.S.—400 Bks.

D 89097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89097

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 866 St. Peter St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie M. Benson

(a) Residence No. 866 St Peter St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John C. Benson

6-DATE OF BIRTH (month, day and year): Jan 21, 1859

7-AGE: 65 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto.

14-

(Informant) Mrs. Margaret Barlage

(Address) To 5 Hanover St

15-

Filed AUG 1 - 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 30/24

17- I HEREBY CERTIFY, That I attended deceased from May 15 19 24 to July 30 19 24

that I last saw h... alive on July 29 24

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(Duration) 3 yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John C. Schwarzenberg M. D

, 19 (Address) 11 New Cross St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	8/1/24 19
20-UNDERTAKER	ADDRESS
Fred A. Krauss & Son	703 Hanover St

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89098 ✓ D 89098

CERTIFICATE OF DEATH.

1924

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 E. Ostend ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Lee Courtney Johnson

(a) RESIDENCE. No. 131 E. Ostend ST., 24th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a ~~If~~ married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~(last)~~ WIFE of Ellsworth D. Johnson

6 DATE OF BIRTH (month, day, and year) November 7, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Edward H. Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Josephine Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant (Husband) Ellsworth D. Johnson

(Address) 131 E. Ostend St.

15 Filed AUG 1 - 1924 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 29, 1924.

that I last saw her alive on July 29, 1924

and that death occurred, on the date stated above, at 5 00 A. m.

The CAUSE OF DEATH* was as follows:

Sunstroke,

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? Riverside Park.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	8/1/24 19
20 UNDERTAKER	ADDRESS
Fred G. Kramer & Son.	703 Hanover St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89099

CERTIFICATE OF DEATH.

46

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 W Franklin St. ST. 19 WARD)

2-FULL NAME Benjamin J Johnson

(a) RESIDENCE. No. 1505 W Franklin St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Perry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hasset Angel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm S. Johnson

(Address) 1505 W Franklin St

15 Filed AUG 1 1924 . 19 Robert P. Harrison, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1924

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to July 29, 1924, that I last saw her alive on July 29, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Do Do

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H Harris, M. D.

(Address) 712 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 5 1924

20 UNDERTAKER John H Toadvine — ADDRESS 142 W Hill St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89100 ✓ 91-002 D 89100

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 49 S Carrollton Ave St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Peregoy

(a) Residence No. 49 S. Carrollton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced WIFE of (or) HUSBAND of Single

6-DATE OF BIRTH (month, day and year) Oct 27 1854

7-AGE, 69 yrs. 9 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Nelson R Peregoy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cedarfield Balto Co

12-MAIDEN NAME OF MOTHER, Ann E. Stake

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs William Daley

(Address) 49 S Carrollton Ave

15- Filed AUG 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year), July 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 13 19 24 to July 31 19 24

that I last saw him alive on July 30 19 24

and that death occurred, on the date stated above, at 8 06 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

2
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm O'Neill M. D.

8/1 1924 (Address) 108 N. Dutton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore — DATE OF BURIAL, July 2 1924

20-UNDERTAKER, John Fields — ADDRESS 120 W Fayette

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89101

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 N. Ashburton St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Peter L. Arculin

(a) Residence No. 16 N. Ashburton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Arculin

6-DATE OF BIRTH (month, day and year) June 17th 1863

7-AGE. 61 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Steward

(b) General nature of industry, business, or establishment in which employed (or employer). Standard Oil Co

(c) Name of employer. Standard Oil Co

9-BIRTHPLACE (city or town) (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Frank L. Arculin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Austria

14- (Informant). Minnie Praley

(Address). 16 N. Ashburton St.

15- Robert P. Harrison, Registrar.

Filed AUG 1 1924 192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 30 1924

17- I HEREBY CERTIFY, That I attended deceased from July 28 19 24 to July 30 19 24 that I last saw him alive on July 30 19 24 and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Acute exacerbation of
an old fibrinous Tuberculosis of both lungs
exaggerated by gas poisoning 3 yrs ago.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrage (Duration) yrs. 0 mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Physical findings, Sputum Examination & X Ray

(Signed) A. Emmanuel Alexander M. D.

, 19 (Address) 336 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Aug 2nd, 1924

20-UNDERTAKER, George Schilling & Sons ADDRESS 1126 E. Monument st

INSTRUCTIONS TO PHYSICIANS, UNDERTAKERS AND OTHERS—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. Every question should be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89102

CERTIFICATE OF DEATH.

REGISTERED NO. D 89102

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 E. Fort Ave. ST., 24 WARD)

2-FULL NAME Michael J. Kyne.

(a) RESIDENCE NO. 118 E. Fort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie E. Kyne.

6 DATE OF BIRTH (month, day, and year) November 11, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elkridge Md.

PARENTS

10 NAME OF FATHER: Timothy Kyne.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elkridge Md.

12 MAIDEN NAME OF MOTHER: Bridget Young.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Nellie E. Kyne. (wife). (Address) 118 E. Fort Ave.

15 Filed AUG 1 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 192 4.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 31 192 4. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md.

DATE OF BURIAL 8/2 192 4

20 UNDERTAKER: J. Frew McCully

ADDRESS 130 E. Fort

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital. 127

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Charlotte Field.

(a) RESIDENCE No. 124 West Ostend. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married.

6 DATE OF BIRTH (month, day, and year) Aug. 3. 1872

7 AGE 51	Years	11 Months	29 Days	If LESS than 1 day, ...hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER A. J. Joyner.

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Francis Stokes

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Va.

14 Informant (Address) John R. Field. 124 west Ostend St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 20 , 1924 , to July 31 , 1924 , that I last saw h[illegible] alive on July 31 , 1924 , and that death occurred, on the date stated above, at 11:50 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

Cholelithiasis.

Chronic Pancreatitis

about 2 mos. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of July 27 1924

Was there an autopsy? yes

What test confirmed diagnosis? Operation + Autopsy.

(Signed) Clement R. Monroe, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash. D.C — DATE OF BURIAL Aug. 4 1924

20 UNDERTAKER Margaret J. Flynn — ADDRESS 1422 Eight St

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item in this mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G1 - 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89104

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 937 Ridgely St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Weber

(a) Residence No. 937 Ridgely St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Johanna Weber

6-DATE OF BIRTH (month, day and year) Nov 18 1886

7-AGE, 37 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Baker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Karl Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Asel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Johanna Weber (Wife)
(Address) 937 Ridgely St

15- Filed AUG 1 - 1924 Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 1 - 1924

17- I HEREBY CERTIFY, That I attended deceased from July 5th, 1924, to August 1st, 1924, that I last saw him alive on July 31st, 1924, and that death occurred, on the date stated above, at 6.45a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Area

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs.

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Yes Date of July 28 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Health Department

(Signed) Edgar D. Pantling, M. D.

July 31, 1924. (Address) 1 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, Aug 4, 1924

20-UNDERTAKER, James Dignan & Son — ADDRESS 1000 S. Paca St

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D. 89105 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 89105

CERTIFICATE OF DEATH. 101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 620 Scott St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Langlotz

(a) Residence No. 620 Scott St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary B. Langlotz

6-DATE OF BIRTH (month, day and year) Jan. 10 1858

7-AGE. 76 yrs. 6 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tinner 684

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William C. Langlotz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henrietta Kern

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Bollman

(Address) 620 Scott St.

15- Filed ..... Robert P. Harrison, Registrar.

AUG 2 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 30 1924

17- I HEREBY CERTIFY, That I attended deceased from July 22 1924 to July 30 1924, that I last saw h. im alive on July 30 24 19....., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Val. Disease of Heart

(Duration) ....yrs. ....mos. 30 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) [signature] M. D.

8.1.24 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug 2, 1924

20-UNDERTAKER, John F. Denny — ADDRESS 715 Light St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks. 89106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89106

CERTIFICATE OF DEATH.

1825 D 89106

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rachel M Davis

(a) Residence No. Bay View Hospital St., Ward. H III
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, white | 5-Single, Married, Widowed, or Divorced, (Write the word.) W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Penn.

PARENTS:
10-NAME OF FATHER, John H Brownley
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia
12-MAIDEN NAME OF MOTHER, unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14- (Informant) Hospital Records
(Address) Bayview Hospital

15- Filed AUG 2 - 1924 Robert P. Harrison Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31/24

17- I HEREBY CERTIFY, That I attended deceased from 7/28/24, 19.. to 7/31/24, 19.. that I last saw her alive on 7/31/24, 19.. and that death occurred, on the date stated above, at 8 00 P m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia Lobar
2 Fracture Left clavicle (Oper.)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray Typhoid vaccination

(Signed) Claude A Blake, M. D.

8-1, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville — DATE OF BURIAL: Aug. 4, 1924

UNDERTAKER: Chas R Bruce & Son — ADDRESS: 1180 W. Mt. Royal ave

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89107

HEALTH DEPARTMENT—CITY OF BALTIMORE

23 D 89107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md General Hosp

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sadie Roberts

(a) RESIDENCE No. 1725 Pulaski ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Robert

6 DATE OF BIRTH (month, day, and year) Sept 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W 037

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) ~~Virginia~~ Howard County, Md

PARENTS

10 NAME OF FATHER Lee Pomroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Moxley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County

14 Informant Mrs Sadie Roberts

(Address) 1725 Pulaski St

15 Filed AUG 2 - 1924 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1924 . to Aug 2 . 1924.

that I last saw her alive on Aug 2 . 1924.

and that death occurred, on the date stated above, at 12.40 Am.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Toxemia Cardiac Failure

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) ..... M. D.

. 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vernon Cem

DATE OF BURIAL Aug 4 1924

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

(Burial Permit Clerk)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 W. Hughes St. ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida M. Hatchett. (C).

(a) RESIDENCE NO 12 W. Hughes St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. 9 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------.

6 DATE OF BIRTH (month, day, and year) October 13, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	--	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Hatchett. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Katie Wright. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Katie Hatchett. (C)(mother). (Address) 12 W. Hughes Street.

15 Filed AUG 2 - 1924, 192... Robert P. Harrison, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

July 31, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn — DATE OF BURIAL Aug 2 1924

20 UNDERTAKER R Z Parham — ADDRESS 902 Leadenhall st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89109

CERTIFICATE OF DEATH.

113

D 89109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Eastern Av. ST., 3 WARD)

2-FULL NAME Frank Dumbrowski

(a) RESIDENCE NO. 1516 Eastern av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Adam Dumbrowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Nowicka

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Adam Dumbrowski (Address) 1516 Eastern Ave

15 Robert P. Harrison, Registrar

AUG 2 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 1, 1924, that I last saw him alive on Aug 1, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Joppa, Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehburger, M. D.

19 (Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem.	Aug 2 - 1924.
20 UNDERTAKER	**ADDRESS**
Jacob Trallowski	428 S. Bond St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89110

CERTIFICATE OF DEATH.

D 89110

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1752 E. Preston ST., 8 WARD)

2-FULL NAME Henry J. Ritterhoff

(a) RESIDENCE NO. 1752 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sophie Ritterhoff

6 DATE OF BIRTH (month, day, and year) Aug 24. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Ritterhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Elsie J. Lauter

(Address) 1752 E. Preston St.

15 Filed AUG 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17 I HEREBY CERTIFY, That I attended deceased from November 19 23, to July 31 24, 19 24

that I last saw h alive on July 30 24, 19 24

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Wilbur A. Meyer, M. D.

(Signed)

7/31, 1924 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 2 1924
20 UNDERTAKER	ADDRESS
Mr. Mrs. J. W. Teufel & Son	801 W. Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89111

CERTIFICATE OF DEATH.

+74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mc Gen. Hosp. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Barbara Micklich

(a) RESIDENCE No. 100 Melvin Ave, Catonsville, Md. ST., WARD Catonsville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. 1 mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Herman Micklich.

6 DATE OF BIRTH (month, day, and year) Feb 24, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER John Tempel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Barbara Micklich

(Address) 100 Melvin Ave, Catonsville

15 Filed AUG 2 1924, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924 to Aug. 1, 1924, that I last saw her alive on August 1, 1924, and that death occurred, on the date stated above, at 7:38 A. m.

The CAUSE OF DEATH* was as follows:

Varicose Ulcer of left leg.
Varicose Veins of left leg.
(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism
(duration) 5 minutes yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of 7-16-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Timanus, M. D.

, 19 (Address) Mc Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 4. 1924

20 UNDERTAKER Mr & Mrs John W. Teufel & Son — ADDRESS 801 W Fayette

Burial Permit

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89112

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 440 N Linwood Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Dittman

(a) Residence No. 440 N Linwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 22, 1896

7-AGE	If LESS than 1 day
53 yrs. 7 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, August Dittman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Jaschied

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Maryland

14- (Informant) Mrs Henry Beckman
(Address) 440 N. Linwood Ave

15- Filed 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 30 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30 1924 to July 30 1924
that I last saw h.. alive on July 30 1924
and that death occurred, on the date stated above, at 10 40P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry J Guerms M. D.
, 19 (Address) 1900 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug. 2, 1924
20-UNDERTAKER	**ADDRESS**
H. Sander Sons	1710 Mad Ave

FG 2 - 1924

THIS IS A PERMANENT RECORD—DEATH CERTIFICATE. WRITE PLAINLY, WITH UNFADING INK—THIS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Cotter

D 89113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89113

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH Johns Hopkins Hospital 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE, (NO. ST., WARD)

2-FULL NAME Margaret M Morris

(a) RESIDENCE NO. 107 Clayton Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John G Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Margaret Kroth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md.

14 Informant John G Morris (Address) 107 Clayton Court

15 Filed AUG 2 - 1924 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute gastro-intestinal Indigestion

(Autopsy at Hopkins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. M. Cotter, M. D.
(Coroner.)

8/2/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL Aug 4 1924

20 UNDERTAKER W. M. Cook — ADDRESS 562 E Fath Ave

NB.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be properly supplied. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89114

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N. Wheeler ST. 16 WARD)

2-FULL NAME Clarence Collins

(a) RESIDENCE. NO. 1022 Wheeler ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Joseph Henry Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Md.

14 Informant (Address) Mrs. Mary S. Collins 1022 Wheeler

15 Filed ..... 19..... Registrar

AUG 2 - 1924

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30 1924 to July 31 1924, that I last saw h[illegible] alive on July 31 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH was as follows:

Acute Gastro Enteritis
(diabetes, probable cause)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

8-1, 1924 (Address) 1 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 2 1924

20 UNDERTAKER [illegible] — ADDRESS [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89115

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-801 ✓ D 89115

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., W of D A. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Lee

(a) Residence No. 807 Ashland Ave. St., ... Ward.....

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Peter Lee

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Sarah Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Hospital Records

(Address) Municipal Hospital W of D A.

15- Filed AUG 2 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/31/24

17- I HEREBY CERTIFY, That I attended deceased from 6/26 ..... 1924 to 7/31 1924

that I last saw h.. alive on 7/31 1924

and that death occurred, on the date stated above, at 6.55 A.M.

The CAUSE OF DEATH* was as follows:

(a) Prostatectomy & Bladder Cystitis

(b) .....

(c) .....

Duration 48 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

Duration ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7/17/24

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Facts.

(Signed) Claude S. Drane M. D.

7-31, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Abbey Cemetery

DATE OF BURIAL. Aug 2, 1924

20-UNDERTAKER. Edward Bryson

ADDRESS 1631 Carlton St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39116 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39116

90

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2055 W. 39th St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Chambers

(a) Residence No. 2055 39th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE Charles Chambers

6-DATE OF BIRTH (month, day and year) July 8 1846

7-AGE 78 yrs. 23 mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), MD

PARENTS.

10-NAME OF FATHER, Barnie McCrossen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), MD

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Hallward W. Chambers

(Address) 2055 W 39 St

15- Filed AUG 2 - 1924 Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1924 to July 31 1924 that I last saw h er alive on July 31 1924 and that death occurred, on the date stated above, at 9 20 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart

dis ease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis lower 1/2 body

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual clinical

(Signed) R R Wantz M. D

Aug 1 1924 (Address) 860 W 36 St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Ceme DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER CHENOWETH & SON, ADDRESS 3517 CHESTNUT AVE

IMPORTANT—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK—should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 89117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89117

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 Union Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Clark

(a) Residence No. 1026 Union Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single~~, Married, Widow~~er~~, ~~Divorced~~ (Write the word) Widowed

5a-If married, widowed or divorced, HUSBAND of (or WIFE of) George W Clark

6-DATE OF BIRTH (month, day and year) March 5–1842

7-AGE 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14-(Informant) Rev Samuel S Clark

(Address) California

15-Filed AUG 2 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 1 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1924 to Aug 1 1924

that I last saw her alive on Aug 1 1924

and that death occurred, on the date stated above, at 1932 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C Hampson M D

8-1 1924 (Address) 3751 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Govans Presbyterian DATE OF BURIAL Aug 3 1924

20-UNDERTAKER CHENOWETH & SON, ADDRESS 2617 CHESTNUT AVE.

AUG 2 1924

GEN. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 89118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89118

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3628 Connecticut Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard E. Allison

(a) Residence No. 3628 Connecticut Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 7 1900

7-AGE 24 yrs. 24 mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS

10-NAME OF FATHER James T Allison

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Laura B Orwig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa

14-Informant James B Allison

(Address) 3625 Connecticut Ave

15-Filed Aug 1 1924 Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31/24

17. I HEREBY CERTIFY, That I attended deceased from July 25 1924 to July 31 1924 that I last saw h[illegible] alive on July 31 1924 and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

Aug 1 1924 (Address) 342 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn | DATE OF BURIAL Aug 4 1924

20-UNDERTAKER'S NAME AND ADDRESS CHENOWETH & SON, 2617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. Exact statement of OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificates.

062 - 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89119

CERTIFICATE OF DEATH.

159-903

D 89119

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Brevard ST., 11 WARD)

2-FULL NAME Rosie Wilkins

(a) RESIDENCE NO. 1212 Brevard ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Col.	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) July 28/24

7 AGE Years	Months	Days 4	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Lua Wilkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Rose Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Rose Wilkins
(Address) 1212 Brevard St.

15 Filed AUG 2 1924 . 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1924 to July 31, 1924.

that I last saw her alive on July 31, 1924,

and that death occurred, on the date stated above, at 3-6 p. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida or congenital deformity.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley, M. D.

Aug 1 1924 (Address) 1230 N. Mt. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	August 2 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 472 Ashland Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it ... that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89120

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 S. Decond St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adaline Dimmick

(a) Residence No. 904 S. Decond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifers. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) single

5a-If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~

6-DATE OF BIRTH (month, day and year) 11/3/23

7-AGE. yrs. 8 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John H. Dimmick

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Molly Seibert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) John H. Dimmick

(Address) 904 S. Decond St.

15. Filed AUG 2 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31/24

17- I HEREBY CERTIFY, That I attended deceased from July 30th, 1924, to July 31st, 1924, that I last saw her alive on July 31st, 1924, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoeal Enteritis

(Duration) yrs. mos. 2d ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. G. Jones M. D.

8/1, 1924 (Address) 1011 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem

DATE OF BURIAL. Aug 2 1924

20-UNDERTAKER. John Ellerich

ADDRESS 2008 Aliceanna

IN. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89121

CERTIFICATE OF DEATH.

113 D 89121

1-PLACE OF DEATH

City of BALTIMORE: (No. 1525 N. Chapel St., 8 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William J. Ely

(a) Residence No. 1525 N Chapel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ ~~or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 29/1923

7-AGE. yrs. 1 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). ~~None~~

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Edward Ely.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary L. Cauburn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) Edith Ely

(Address) Balto

15- Filed, AUG 2 1924 192 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 1 1924

17- I HEREBY CERTIFY, That I attended deceased from 7-24 19 24 to 8-1 19 24

that I last saw him alive on 8-1 19 24

and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Enteritis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & sign

(Signed) David Miller M. D.

. 19 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Aug 7 19 24

20-UNDERTAKER, John Uelrich ADDRESS 2008 Orleans

N B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39122 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39122

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH Highland Home

City of BALTIMORE: (No. 10 S. Eleventh St. 76 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Ross Hill

(a) Residence No. 10 S. Eleventh St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lena Rosenthal

6-DATE OF BIRTH (month, day and year) Feby 7-1879

7-AGE. 45 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hoisting Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Potomac Pottery Co

9-BIRTHPLACE (city or town) (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER Amos Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant). Rose V. Hill

(Address). 3504 E. Lombard

15- Filed AUG 2 - 1924 19 Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). August 1/24

17- I HEREBY CERTIFY, That I attended deceased from July 7 1924 to August 1 1924

that I last saw him alive on July 21 1924

and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) W. H. Ingram M. D.

, 19 (Address) 2439 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross — DATE OF BURIAL, Aug 4, 1924

20-UNDERTAKER. John Ulrich — ADDRESS 2008 Orleans

A B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89123

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Marsh

(a) RESIDENCE No. 2409 Christian st ST., C WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6-1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Marsh

11 BIRTHPLACE OF FATHER (city or town) Johnstown
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Tessie Burnotes

13 BIRTHPLACE OF MOTHER (city or town) Chicago
(State or country) Illinois

14 Informant Mrs. Joseph Marsh
(Address) 2409 Christian Street

15 Filed AUG 2 1924 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. a few days mos. ds.

CONTRIBUTORY (Secondary) Heart & Food

(duration) yrs. mos. ds.

(Signed) W K Gorsuch, M. D. (Coroner.)

Aug 1, 1924 (Address) 111 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 2 1924
20 UNDERTAKER Jos Block	ADDRESS 1003 N Bal St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 89124

HEALTH DEPARTMENT—CITY OF BALTIMORE

6520 D 89124

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3347 Cedar Ave ST., 13 (WARD)

2-FULL NAME Kenneth Lee Harper

(a) RESIDENCE NO. 3347 Cedar Ave. ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 21-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer Harper

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lola Shaffer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Elmer Harper (Address) 3347 Cedar Ave.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

AUG 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1924

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1924, to Aug 1, 1924, that I last saw him alive on Aug 1, 1924, and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Blood.

(Signed) Edward Hall, M. D.

8/2, 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug. 4 1924

20 UNDERTAKER Horace H. Burgee — ADDRESS 362 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2119 Frazier St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard D. Willig

(a) Residence No. 2119 Frazier St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 26-1923

7-AGE, ...yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George L. Willig

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Lillie May Jones

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Lillie May Willig

(Address) 2119 Frazier St.

15- Filed ..... 192.

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

AUG 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7/31/24

17- I HEREBY CERTIFY, That I attended deceased from June 1- 24 19..... to July 31/24 19.....

that I last saw him alive on July 30/24 19.....

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Enteritis

(Duration).....yrs.....mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Harris, M. D.

, 19 (Address) 1900 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet Cem	Aug 2, 1924
20-UNDERTAKER	ADDRESS
Jas C. Miller	2334 Jefferson

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89126

CERTIFICATE OF DEATH.

84

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1631 N. Milton Av St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine S. Strathmann

(a) Residence No. 1631 N. Milton Av St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late Wm Strathmann

6-DATE OF BIRTH (month, day and year) June 2/64

7-AGE. 60 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Henry Pilgrim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eva E. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Miss Minnie Strathmann

(Address) 1631 N. Milton Av

15- Filed 1924 Robert F. Harrison, 192

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31/24

17- I HEREBY CERTIFY, That I attended deceased from July 21 19 24 to July 31 19 24

that I last saw h.. alive on July 29 19 24

and that death occurred, on the date stated above, at 10-55 A M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Bernbeck M.D.

F-1 192 (Address) 1531 E. North Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St. Mathews	8/3 ....., 1924
20-UNDERTAKER Philip Henry	ADDRESS 2016 Orleans St

G2

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89127

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 N. Madeira St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Weber

(a) Residence No. 213 N. Madeira St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: late Elizabeth Weber

6-DATE OF BIRTH (month, day and year): Jan 30/43

7-AGE. 81 yrs. 6 mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer): Bricklayer

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Fred. Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Minnie Wieber

(Address) 213 N. Madeira

15- Filed ... Robert P. Harrison, Registrar.

AUG 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 30/24

I HEREBY CERTIFY, That I attended deceased from July, 1923, to July 30th, 1924

that I last saw him alive on July 30th, 1924

and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

(Address) 154 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL, 8/2, 1924

20-UNDERTAKER: Philip Herwig

ADDRESS 2016 Oldeans

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ... Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89128

74-B 89128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Ensor St ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth L. Enright

(a) RESIDENCE No 1201 Ensor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawernce Enright

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos. Eveson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thos L Enright (son)
(Address) 1201 Ensor St

15 Filed AUG 2 - 1924 192 Robert R. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy
(Found dead in bed)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Callen, M. D.
(Coroner.)

8/2/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Aug 4 192 4

20 UNDERTAKER W. C. Windfield — ADDRESS 914 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... of sick CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89129

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Stricker ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Perry

(a) RESIDENCE NO. 1123 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none old
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ernest Perry

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Amby

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Eliz. Amby
(Address) 1123 N. Stricker St.

15 Filed AUG 2 - 1924 Robert P. Harrison, Registrar

1658

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uro-Colitis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessey M. D.
(Coroner)

Aug. 1, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 192...

20 UNDERTAKER

ADDRESS

AUG 1924

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89130

CERTIFICATE OF DEATH.

185 D 89130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Reilly ~~Mrs Kate A. O'Reilly~~

(a) RESIDENCE No. 1217 E. North Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Reilly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Norton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Philip Reilly
(Address) 1909 Cecil Avenue

15 Filed AUG 2 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to Aug 2, 1924, that I last saw h.w alive on Aug 2, 1924, and that death occurred, on the date stated above, at 4.45A m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Edema of lungs
Septicemia from Pyelitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Decompensatio cordis - Pneumonia & Pyelitis Pelvis

(duration) yrs. 8 mos. 8 ds.

18 Where was disease contracted if not at place of death? Home (Mary)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Dr. Louis Kuphner, M. D.

. 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/4 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89131 ✓ 12 D 89131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St., 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lina Hessel

(a) RESIDENCE No. 1911 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? 37 yrs. 11 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Hessel

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hough.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germa

12 MAIDEN NAME OF MOTHER Eliz. Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Otto Hessel
(Address) 1911 Clifton ave

15 Filed AUG 2 - 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS mation should be carefully supplied. AGE should b CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of ck of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic coma

(duration) yrs. mos. 1 ds.

(Signed) J. & T. Hennessy M. D. (Coroner.)

July 31 1924 (Address) 2802 Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loud German Essa	Aug 3 1924

20 UNDERTAKER Peter Nicolaus ADDRESS 2061 Eastern Ave

Spec–12-23-21–E.B.R.S.–400 Eks.

D 89132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89132

CERTIFICATE OF DEATH. 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 N. Chester St., ... Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adell Wolf

(a) Residence No. 104 N. Chester St., ... Ward.....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos, ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Dora Wolfe

6-DATE OF BIRTH (month, day and year)

7-AGE. 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Felix Wolf

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER Rifa Warshofsky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jacob Lewis

(Address) 1439 E. Baltimore

15- Robert P. Harrison,

Filed ..... 192.... Registrar.

Burial Permit Clerk.

AUG 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/1/24

17- I HEREBY CERTIFY, That I attended deceased from April 4 1924 to aug 1st 1924

that I last saw him alive on aug 1st 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(over)

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H Zenberg M. D

8/1 1924 (Address) 1826 E. Oliver D

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Int Corp

DATE OF BURIAL. 8/3 1924

20-UNDERTAKER. Jacob Lewis

ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89133

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital ST., ... WARD)

2-FULL NAME James Harney

(a) RESIDENCE NO. Bayview Hospital ST., ... WARD 16

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept 15/1857 (Autopsy)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired #10
(b) General nature of industry, business, or establishment in which employed (or employer) City Laborer
(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Luke Harney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address) Bayview

15 AUG 3 - 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Arterio Sclerosis
Senile Nephritis
Dilatation of Heart
(No Homicide Por)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McGuire, M. D.
Coroner
Aug 2, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In this State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? Bayview
Former or usual residence 245 4 Bay St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetery DATE OF BURIAL Aug 4 1924

20 UNDERTAKER William G. Schaffer ADDRESS 816 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MSA

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89134 CERTIFICATE OF DEATH. 75-001 D 89134

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 W Balt ST.; WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Garbus

(a) RESIDENCE. NO. 1933 W Balt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Eli Garbus

6 DATE OF BIRTH (month, day, and year): Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Morris Garbus (Son) 2010 W Balt St

15 Filed AUG 3 - 1924 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924 to Aug 2, 1924 that I last saw h alive on Aug 2, 1924 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Toxemia Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Left side Hemiplegia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

8/2 1924 (Address) 3027 W Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Lebanon	8/3 1924

20 UNDERTAKER: Jack Lentz 1439 ADDRESS: Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89135

CERTIFICATE OF DEATH. 181-003 D 89135

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Scheer

(a) RESIDENCE NO. 18 N. Washington ST., ... WARD 2

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Scheer

6 DATE OF BIRTH (month, day, and year) Oct 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Mens Clothing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1409 E Balto St

AUG 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1924

17 I HEREBY CERTIFY, That I attended deceased from July 31st, 1924, to Aug 1st, 1924, that I last saw h. alive on Aug 1st, 1924, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) ..... yrs. ..... mos 1 hrs.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Nathan Louis Kramer M. D.

Aug 1, 1924 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Aug 3 1924
20 UNDERTAKER Jacob Levis	ADDRESS 1434 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89136 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89136

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolphus Crane

(a) Residence No. 827 Harlem St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (Month, day and year) 1835

7-AGE 89 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer .....

9-BIRTHPLACE (city or town). (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Anthony Crane

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address) Bay View Hospital

AUG 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-1-24

17- I HEREBY CERTIFY, That I attended deceased from 7-17, 1924 to 8-1, 1924

that I last saw ~~him~~ alive on 8-1, 1924

and that death occurred, on the date stated above, at 3:50 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Heard, M. D.

8-1, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL. Aug 4, 1924

20-UNDERTAKER. Williams Cook — ADDRESS 502 E North

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 89137 Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No. 420 West 23rd St., ... Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice A. Souders

(a) Residence No. 420 West 23rd St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm A Souders

6-DATE OF BIRTH (month, day and year) Nov 16

7-AGE 7 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS:
10-NAME OF FATHER Thos. Angel
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md
12-MAIDEN NAME OF MOTHER Mary Deal
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14-INFORMANT Wm A Souders
(Address) 1121 Madison Ave

15-Filed AUG 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 2 24

17-I HEREBY CERTIFY, That I attended deceased from Aug 20 1921 to Aug 2 1924
that I last saw her alive on Aug 2 1924
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

E Pancreas
Liver
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
Chronic Nephritis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Richardson M. D.
Aug 3. 1924 (Address) 112 W. 20 St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, (CREMATION OR REMOVAL) Loudon Park | DATE OF BURIAL. 8/4 1924

20-UNDERTAKER. W M Cook | ADDRESS Solesville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Talbott, 1353 W. Pratt Ave

D 89138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF ~~DEATH~~.

46 D 89138

Registered No.....

1-PLACE OF DEATH Southern Hospital

City of BALTIMORE (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle Millikin

(a) Residence No. 1121 Madison Ave St.,.....Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE William Millikin

6-DATE OF BIRTH (month, day and year) Apr 17, 1859

7-AGE. 65 yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ill.

PARENTS.

10-NAME OF FATHER William Townsend

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Levara

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), South Carolina

14-

(Informant) Wallace Millikin

(Address) 1121 Madison Ave.

AUG 3 - 1924

ROBERT P. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1923 to Aug 1 1924 that I last saw h. w. alive on July 31 1924 and that death occurred, on the date stated above, at 5.50 P. m. The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) 1 yrs. 6 mos. x ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7-24-24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edw Talbott M. D

8/2, 1924 (Address) 1353 W. Pratt

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood — DATE OF BURIAL. Aug 4, 1924

20-UNDERTAKER. William Cook — ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89139

90 D 89139

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2522 E. Madison St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Dietz

(a) Residence No. 2522 E. Madison St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mollie E. Dietz

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE. 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchcl't.

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 186

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Casper B. Dietz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

11- (Informant) Lawrence Dietz

(Address) 625 N. Madeira Ave

13- FILED ..... 192 ROBERT R. KRAUTER, Burial Permit Clerk

APR 3 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31/24

17- I HEREBY CERTIFY, That I attended deceased from July 1 19 24 to July 31 19 24

that I last saw him alive on July 31 19 24

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Acute Diffuse Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

8/1 19 24 (Address) 800 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Aug 4 1924

20-UNDERTAKER. Fred Evers Son

ADDRESS 1906 Eastlake Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89140

17360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D 89140

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Eugene Whitcomb

(a) RESIDENCE NO. 5521 Aloysius Ave ST., ... WARD .....
(Usual place of abode) Pittsburg Pa
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. — mos. 9 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Evelyn Whitcomb

6 DATE OF BIRTH (month, day, and year) Dec 25-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal - Gas

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER Hale Whitcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Jane Pitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 AUG 3 - 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2- 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug 2-, 1924,

that I last saw him alive on Aug 2-, 1924,

and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) 1 yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Thale M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pittsburg Pa	Aug 7 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 89141

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Rice St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Walter Hall

(a) RESIDENCE NO. 1027 Rice St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26.1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Meat packing

(c) Name of employer Wilson-Martin Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annearundel Co.

12 MAIDEN NAME OF MOTHER Gertrude Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annerundel Co. Md.

14 Informant Walter Hall
(Address) 1027 Rice St.

15 Filed AUG 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1/1924

17 I HEREBY CERTIFY, That I attended deceased from July 30th. 1924 to Aug. 1st 1924.

that I last saw him alive on Aug. 1st. 1924.

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acct. Supperative Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

. 19 (Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waterbury	Aug 3rd 1924
UNDERTAKER	ADDRESS
Hanna E. Wright	364 W. Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89142

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Bay View St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Geo. Bentelspacher

(a) Residence No. 2643½ Fremont Ave St., Ward 20th

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Edna Thomas

6-DATE OF BIRTH (month, day and year) Aug 16-1881

7-AGE, 42 yrs. 11 mos. 15 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Furniture 425

(b) General nature of industry, business, or establishment in which employed (or employer)... Dealer

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER Geo. Bentelspacher

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER Barbara Wolfenstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Md.

14- (Informant) Lena E. Bentelspacher

(Address) 2643½ Fremont Ave

15- AUG 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

1804 Frankland

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 31 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30, 1924 to July 31st 1924

that I last saw him alive on July 31st 1924,

and that death occurred, on the date above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Gangrene of Lung.

Diabetes Mellitus.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of...

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) James Fiske M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 4th, 1924
20-UNDERTAKER	ADDRESS
F B Kelly Inc	2216 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89143

CERTIFICATE OF DEATH.

74-001 D 89143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2555 Mc Henry St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Magdalena Roslein

(a) Residence No. 2555 Mc Henry St., ND Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND (or WIFE) of Gustav Roslein

6-DATE OF BIRTH (month, day and year) Nov 22-1850

7-AGE. 73 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ——

(b) General nature of Industry, business, or establishment in which employed (or employer) ——

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Hungary

PARENTS.

10-NAME OF FATHER Wm Wilhelm

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Hungary

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Hungary

14- (Informant) Mrs M. Cusate

(Address) 2555 Mc Henry St

15- Filed AUG 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 1st 24

17- I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to July 31, 1924, that I last saw h.. alive on July 31, 1924, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Harry Glazomare M. D.

Aug 2 1924 (Address) 2687 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Aug 4th 1924

20-UNDERTAKER. F. B. Wellpert

ADDRESS 1850 N. Ballo St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it r TION is very important. See instructions on b

Cor.—1-12-25—M&T—100 Bks.

D 89144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 89144

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Goldstraw.

(a) RESIDENCE NO. 419 Calvin Ave. ST., WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Clara B. Goldstraw.

6 DATE OF BIRTH (month, day, and year) October 25, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) O'Mera Contracting

(c) Name of employer Company.

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER George Goldstraw.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Elizabeth Redfern.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Clara B. Goldstraw. (wife).

(Address) 419 Calvin Ave.

15 AUG 3 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Right Femur Left Humerus Right Radius. Probable fracture of skull & spine. Shock. Accidental fall from a scaffold by slipping of a robe.

(Duration) ... yrs. ... mos. 2 ds

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Aug. 2nd, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Accident War Memorial Bldg. August 1st, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon Park Cemetery

DATE OF BURIAL Aug 4th 1924

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89145

CERTIFICATE OF DEATH.

52

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1017 N. Payson St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Haynie

(a) Residence No. 1017 N. Payson St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Haynie

6-DATE OF BIRTH (month, day and year) April 27 1844

7-AGE. 80 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, William Berry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14. (Informant) John A. Haynie

(Address) 1017 N. Payson St

15. AUG 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

1101 Eutaw

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-1-1924

17. I HEREBY CERTIFY, That I attended deceased from June 8 1923 to Aug 1 1924 that I last saw her alive on July 29 1924 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chron. Rheumatism & Neuritis

(Duration) 8 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Complications unknown.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. C. Conser M. D.

8-2 1924 (Address) 1101 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Reisterstown Md DATE OF BURIAL, Aug 3 1924

UNDERTAKER. John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89146

CERTIFICATE OF DEATH.

46 D 89146

Registered No.....

1-PLACE OF DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Asylum St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Cerino

(a) Residence No. 25 North Central Ave St., 5 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr.

6-DATE OF BIRTH (month, day and year) 1877.

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 169

(c) Name of employer .....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Louis Lafortte

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14- (Informant) Hospital Records

(Address) Bay View Hospital

15- Dec 3 - 1924. 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8/2/24

17- I HEREBY CERTIFY, That I attended deceased from 5/26....., 1924, to 8/2....., 1924, that I last saw her alive on 8/2....., 1924, and that death occurred, on the date stated above, at 5.20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Cervix Uteri with General metastases

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? 25 N. Central Ave

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jas. P. Crampe. M.D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Dec 4 19.24
20-UNDERTAKER	ADDRESS
Randle Apfel & Son	570 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1735-11

Spec.—1-10-21—M&T—1500 Bks.

D89147 ✓ D89147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 63

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Newland

(a) RESIDENCE NO. Oakhill W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Newland

6 DATE OF BIRTH (month, day, and year) Sept. 17 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Oakhill W. Va

PARENTS

10 NAME OF FATHER Ranj Newland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Maria Studdleston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Johns Hopkins Hospital (Address)

15 AUG 3 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to August 2, 1924, that I last saw him alive on August 2, 1924, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Addison's Disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Laurence Kolb, M. D.

, 19 (Address) Johns Hopkin Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill W. Va

DATE OF BURIAL aug 4 1924

20 UNDERTAKER H. C. Branning Son

ADDRESS 517 Belvedere St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89148

CERTIFICATE OF DEATH

7H-00 Disney

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Warwick Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Susannah Winny

(a) RESIDENCE NO. 1016 Warwick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Wesley Disney

6 DATE OF BIRTH (month, day, and year) Feb 19-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Allen Mayfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) L A Disney 2602 Huntingdon Ave

15 Filed AUG 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1924, to date of death.

that I last saw her alive on Aug. 1. 1924,

and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mo. ds.

CONTRIBUTORY (Secondary) Arterio. Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emory Lee Harris, M. D.

, 19 (Address) 814 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery M.C.Co. DATE OF BURIAL Aug 4 1924

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89149

CERTIFICATE OF DEATH. 74-001 D 89149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 E Preston ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marianne Horn

(a) RESIDENCE No. 15 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Horn

6 DATE OF BIRTH (month, day, and year) Sept 12 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	76	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Corsets & Retouns 945

(b) General nature of industry, business, or establishment in which employed (or employer) Retired in gross

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Memil Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Milton E. Horn

(Address) Freeport Long Island N.Y.

15 Filed AUG 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1 1924

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1924, to Aug 1, 1924,

that I last saw her alive on Aug 1, 1924,

and that death occurred, on the date stated above, at 12 50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis and degeneration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley R. Townsend, M. D.

8/2, 1924 (Address) 1856 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 4 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89159

49

REGISTERED NO. 0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth F. Wells

(a) RESIDENCE NO. 533 W. Calhoun St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: George W. Wells

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records

15 AUG 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/24. 19

17

I HEREBY CERTIFY, That I attended deceased from 7/2/24, 19, to 8/3/24. 19,

that I last saw her alive on 8/3/24, 19

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas.

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Cholecystenterostomy

Did an operation precede death? Yes Date of 8/2/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Gross

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkton Md

DATE OF BURIAL: Aug 7 1924

20 UNDERTAKER: W. J. Tickner

ADDRESS: Rear

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89151

CERTIFICATE OF DEATH.

22

D 89151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Oak Rd ST., Woodland Ave WARD) 17

2-FULL NAME Margaret E Wood

(a) RESIDENCE No. Oak Rd ST., Woodland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec (23)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	0	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Florence Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Johnstown Pa.

14 Informant Mrs F. Wood

(Address)

15 Filed AUG 4 1924, 19.... ROBERT E. KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1924

17

I HEREBY CERTIFY, That I attended deceased from July, 1924, to Aug 3, 1924, that I last saw her alive on Aug 2, 1924, and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(duration) Definite 1½ hrs mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea & Enteritis

(duration) 0 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms only

(Signed) C. B. Connor, M. D.

Aug 3 1924 (Address) Park Ave & Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL aug 4 1924

20 UNDERTAKER Wm Cook — ADDRESS 1501 E Balto

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89152

D 89152

CERTIFICATE OF DEATH.

X 49

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1714 Guilford av St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis T. Buckingham

(a) Residence No. 1714 Guilford av St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maude L. B.

6-DATE OF BIRTH (month, day and year) Dec 3 60

7-AGE. 63 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Dennis B.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Shipley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mrs Maude B.

(Address) Frederick Md

15-

Filed AUG 4 - 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 2- 1924

17- I HEREBY CERTIFY, That I attended deceased from June 9- 19.24 to Aug 2- 19.24

that I last saw h[illegible] alive on July 1- 19.24

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Gustav Weyerich M. D.

Aug 3. 1924 (Address) 1120 N. Paca St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mechanicsville Md	Aug 4, 1924
20-UNDERTAKER,	ADDRESS
W M Routson	2238 N Monta

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89153

CERTIFICATE OF DEATH.

113 D 89153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Monumental St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Theresa Kaliszak

(a) RESIDENCE No. 2008 Monumental St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

(If not a resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Kaliszak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Julia Kaliszak (Address) 2008 Monumental St

15 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30 1924 to Aug 3 1924

that I last saw h— alive on Aug 2 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Dentition

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY (Secondary) X Enteritis - "Meningitis"

(duration) yrs. mos. X 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. T. Rodas, M. D.

, 19 (Address) 1904 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Aecidental, Suicidal, or Homieidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Aug 4 1924

20 UNDERTAKER John M Weber ADDRESS 803 Bank

UG4

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89154

CERTIFICATE OF DEATH.

D 89154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1739 The Cathedral ST., WARD) 14

2-FULL NAME Mary V. Young

(a) RESIDENCE NO. 1739 Fredrick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Cd

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Wm. Young

6 DATE OF BIRTH (month, day, and year): March 22 1874

7 AGE — Years: 50 — Months: 5 — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Albert J. Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary V. Young

(Address): 1739 McCulloh St.

15 Filed ROBERT E. KRAUTZ, 19

Burial Permit Clerk. Registrar

UG 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 19 24.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 24. to Aug. 1, 19 24.

that I last saw her alive on Aug. 1, 19 24

and that death occurred, on the date stated above, at 10 — m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene

of left foot.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms & Course

(Signed) W. F. Carey, M. D.

, 19 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemy — DATE OF BURIAL: 8/4/24

20 UNDERTAKER: Mrs Geo. H. Holland — ADDRESS: 1681 Division Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89155

CERTIFICATE OF DEATH.

32 D 89155

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1702 Patterson Park Ave. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Christina M. Borbel

(a) Residence No. 1702 Patterson Park Ave. St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 8th 1908

7-AGE. 16 yrs. mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School girl

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Gottfred Borbel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary E. Jung.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14-(Informant). Gottfred Borbel

(Address). 1702 Patterson Park Ave

15-

Filed AUG 4 - 1924 for [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 3rd 1924

17- I HEREBY CERTIFY, That I attended deceased from July 26th 1924 to Aug 3rd 1924

that I last saw h. alive on Aug. 2nd 1924

and that death occurred on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Lupus Volgaris, Antrior nasal cavity and ali of nose. Tubercular.

(Duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tubercul or meningatis

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Geo. W. Cross M. D.

, 19 (Address) 2409 Nd. ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	8/5 1924
20-UNDERTAKER. Philip Herrig	ADDRESS 2016 Orleans St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 89156

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 3221 Powhatan Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caesar H. Rosenheim

(a) Residence No. 3221 Powhatan Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie H. Rosenheim

6-DATE OF BIRTH (month, day and year) Sept 8th 1866

7-AGE. 57 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) Liquor Merchant

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Parkersburg W. Va

PARENTS.

10-NAME OF FATHER, Henry Rosenheim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Carrie Guggenheimer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mr. Albert Rosenheim

(Address) 1221 Linden Ave

15- Filed AUG 24 1924 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/3/24.

17- I HEREBY CERTIFY, That I attended deceased from 1912, 19..... to Aug 3, 1924, that I last saw ~~him~~ alive on Aug 3, 1924, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(Duration) 17+ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tabetic Crisis cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Wassermann

(Signed) Irving J. Spear M. D.

8/3, 1924 (Address) 924 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ohev Shalom Cem. DATE OF BURIAL, 8/5/1924

20-UNDERTAKER. David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89157.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 89157.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Highland & South Ave. St., Mt Washington Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. M Lloyd Morrison

(a) Residence No. Highland & South Ave St., Mt Washington Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Morrison

6-DATE OF BIRTH (month, day and year) Dec 14, 1880

7-AGE, 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Reporter Sun

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert Morrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Frances Walley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-

(Informant) Ada Rollins Morrison

(Address) Highland & South Ave

Filed AUG 4 - 1924 ROBT. P. KRAUTZ Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1924, to Aug 2, 1924

that I last saw h.. alive on July 30, 1924

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. A. Beard M. D.

Aug 2, 1924 (Address) 2105 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loud Ridge	Aug 4, 1924
20-UNDERTAKER. George J. Smith	ADDRESS 153 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1 10-21 M&T 1500 Blks.

D 89158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D. 89158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4019 Penhurst ST., (WARD)

2-FULL NAME Kate Minks

(a) RESIDENCE No. 4010 Penhurst Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Minks

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER Elise Traine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Mrs Ella Rohlfing

(Address) 233 S. Arlington Ave

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1924, to Aug. 3, 1924.

that I last saw her alive on Aug 3, 1924.

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture

(Signed) Amerik Borrello, M. D.

, 19 (Address) 370 Liberty Hts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Aug 4 19 24
20 UNDERTAKER George J. Smith	ADDRESS 532 Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89159

CERTIFICATE OF DEATH.

129 D 89159

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 137 N. Chester St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*2-FULL NAME. Catherine Dignan

(a) Residence No. 137 N Chester St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Dignan

6-DATE OF BIRTH (month, day and year) Dont Know

7-AGE. 83 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. John Dignan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Finnegan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Julia A Dignan (Sister)

(Address) 137 N. Chester St

15- Filed, AUG 4 1924, 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 2, 1924, that I last saw h.. alive on Aug 2, 1924, and that death occurred, on the date stated above, at 10.00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? physical exam

(Signed) Jas. Upton, M. D.

Aug 2, 1924 (Address) 2231 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Aug 5, 1924

20-UNDERTAKER. Robt J Turner & Son ADDRESS 4 N Bway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

16996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89160

1-PLACE OF DEATH D 89160 CERTIFICATE OF DEATH. 126

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hadymski

(a) RESIDENCE NO. 3209 Elliott St. ST., 1 WARD 26

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 17, 1919.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Records John Hopkins Hospital

15 Filed AUG 4 1924, 19.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to August 2, 1924, that I last saw him alive on August 2, 1924, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows: Acute Generalized Peritonitis due to

(duration) yrs. mos. 10 ds. CONTRIBUTORY (Secondary) Subacute Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bagg M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Stanislaus Bem | DATE OF BURIAL Aug 5 1924

20 UNDERTAKER Stephen J Kraikowski | ADDRESS 1 Kenwood

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 8916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D 8916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N Belnord Ave WARD)

2-FULL NAME Lee P Rodgers

(a) RESIDENCE No. 603 N Belnord Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Rodgers

6 DATE OF BIRTH (month, day, and year) July 30 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H J J Nelson

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Henry Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Ida Rodgers

(Address) 603 N Belnord Ave

15 AUG 4 - 1924

ROBERT R. KRAUTER, Registrar

Asst Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7- 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-9-24, 19..., to 8-7-24, 19...

that I last saw him alive on 8-1-24, 19...

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastric

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Peptic Ulcer

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick O Guyman, M. D.

(Address) 1913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Aug 5 1924
20 UNDERTAKER	ADDRESS
Jas C. Miller	233 N Gilmor 85

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89162

CERTIFICATE OF DEATH.

D 89162

84 REGISTERED NO.

1-PLACE OF DEATH Baltimore City

CITY OF BALTIMORE: (No.) 744 Foundry Court ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Edward Hall

(a) RESIDENCE NO. 744 Foundry Court ST., W WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 18-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David E. Hall Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Egan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr David E Hall

(Address) 744 Foundry Court

15 Filed AUG 4 - 1924, 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3. 1923, to July 3. 1924.

that I last saw him alive on July 2- 1924

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Mental Deficiency

(duration) 2 yrs. 6 mos. 16 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) W. K. Ingalls, M.D.

, 19 (Address) 429 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 4, 19 24

20 UNDERTAKER John Hagan & Son — ADDRESS

Per P. J. Cowan 901 Hollins St.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89163 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89163

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 949 Hollins St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry M. Mugary

(a) Residence No. 949 Hollins St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Mugary

6-DATE OF BIRTH (month, day and year) Sept 16 1872

7-AGE. 51 yrs. 10 mos. 17 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lamp Tester

(b) General nature of industry, business, or establishment in which employed (or employer) Testing Lamps

(c) Name of employer Not Employed.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland.

PARENTS.

10-NAME OF FATHER. Moses Mugary

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-Informant. Wife Address 949 Hollins St.

15-Filed 1924 ROBERT R. KRAUTH, 192 Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 2 1924

17- I HEREBY CERTIFY, That I attended deceased from July 13 1924 to Aug 2 1924

that I last saw h/m alive on July 31 1924

and that death occurred, on the date stated above, at 6:45 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) George E. Shannon M. D

, 19 (Address) 700 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Aug 5 19 24

20-UNDERTAKER. Wm J Cowan ADDRESS 901 Hollins St

UG4

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89164 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89164

CERTIFICATE OF DEATH. 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 829 Sarah Ann St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Horace Blake

(a) Residence No.... 829 Sarah Ann St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Blake

6-DATE OF BIRTH (month, day and year) 1849

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Kent County Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Violet Allen

(Address) 829 Sarah Ann St

15- Filed....., 192.... Robert P. Harrison, Registrar.

AUG 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 2 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 2, 1924 that I last saw h in alive on July 31, 1924 and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus Aureus

(Signed) Jas L Hoffman, M. D.

8-4, 1924 (Address) 3462 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Virginia Mid Kent County, Md. DATE OF BURIAL, August 5, 1924.

20-UNDERTAKER, Mrs Katie R. Williams ADDRESS 322 N. Schroeder St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89165

CERTIFICATE OF DEATH.

113

D 89165

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 910 Battery ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm T. Earl

(a) Residence No. 910 Battery ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 30, 1924

7-AGE, ... yrs. 4 mos. 4 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Earl

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country),

12-MAIDEN NAME OF MOTHER, Elvira Fogwell

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) John Earl

(Address) 910 Battery ave

15- (Filed) AUG 4 - 1924 Robert F. [illegible], 19?..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug 2, 1924, that I last saw him alive on Aug 2, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 9 ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Smith M. D.

Aug 3, 1924 (Address) 69 W. Lee St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, Aug 4, 1924

20-UNDERTAKER, Perkins & Sikler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89166 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89166

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1714 N. Bond St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Annick

(a) Residence No. 1714 N. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 10, 1842

7-AGE. 82 yrs. 1 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John W. Annick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Maria L. Leach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant) Leonard Annick

(Address) 1714 N. Bond

13- Filed 19.. Robert P. Harrison, Registrar.

AUG 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 3, 1924

I HEREBY CERTIFY, That I attended deceased from Feb 17- 1924 to Aug 3 1924

that I last saw h.er alive on Aug 2 1924

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion

Acute Enteritis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. E. Hall M. D.

Aug 3, 1924 (Address) 1631 E North Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19..
Baltimore	Aug 6, 1924
20-UNDERTAKER. Sirkler & Sirkler	ADDRESS 1734 Eager

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89167

D 89167

41

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

2-FULL NAME Wm. A. Bogy

(a) RESIDENCE No 1817 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Bogy

6 DATE OF BIRTH (month, day, and year) June 5/1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	[illegible]	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman-Highways
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer Dept.
(c) Name of employer Balto. City Md

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. F. Bogy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Carrie Cropper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Regina Bogy
(Address) ~~1817 E. Chase St~~

15 Filed AUG 4 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-from infection of upper lip-cellulitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature], M. D. (Coroner.)

8/4/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Aug 7 1924

20 UNDERTAKER Fuhrler & Fuhrler — ADDRESS 1734 Eager

N.B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89168 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89168

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Home for Incurables St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Staum

(a) Residence No. Guilford Ave & 21st. St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 27-1844

7-AGE. 80 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Staum

11-BIRTHPLACE OF FATHER (city or town) Switzerland
(State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Ross

13-BIRTHPLACE OF MOTHER (city or town) Ohio
(State or Country).

14- (Informant) John R. Staum
(Address) 216 Light St

15- AUG 4 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 2nd. 1924

17- I HEREBY CERTIFY, That I attended deceased from January 3 1924 to Aug. 2- 1924
that I last saw her alive on Aug. 2-1924 1924
and that death occurred, on the date stated above, at 8.30 P.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Paralysis agitans
Locomotor Ataxia (Duration) 6 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis?
(Signed) Thos. J. Mackey M. D.
Aug 3- 1924 (Address) 2125 Maryland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cemetery	Aug 5th, 1924
20-UNDERTAKER, Putnam Moore	ADDRESS 1723 N Lafayette Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Eloie Townsend

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89169

CERTIFICATE OF DEATH.

114

D 89169

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 561 Orchard St ST., WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clois Townsend

(a) RESIDENCE NO. 561 Orchard St ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of Thos. Townsend

6 DATE OF BIRTH (month, day, and year) about 1882 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Fred Manop

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Miranda Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Thos. Townsend
(Address) 561 Orchard St.

15 Filed Aug 4 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said —— (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis
(Duration—Time of death).

CONTRIBUTORY (Secondary) ac. Dil. of heart 5 minutes
(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Aug 2, 1924 (Address) 2402 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs. ... mos., ... ds. In the State ... yrs. ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Coll S. C. DATE OF BURIAL: Aug 4 1924

20 UNDERTAKER: Samuel T Kennedy ADDRESS: W Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 4 - 1924

Burial Permit Clerk

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89170

CERTIFICATE OF DEATH.

7/4-001 D 89170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 Gengl St. ST., WARD)

2-FULL NAME Denis Franklin

(a) RESIDENCE NO. 743 Gengl St. ST., WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Franklin

6 DATE OF BIRTH (month, day, and year) Sept. ? 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Henry Whitfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Benjamin Franklin 743 Gengl St.

15 Filed AUG 4 - 1924, 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asthenia - Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Aug 3. 1924 (Address) 280 Courtland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Aug 4 1924

20 UNDERTAKER David T. Kemsley ADDRESS 1718 N Eutaw

M. B.—WRITE PLAINLY, WITH UNFADING INK—AGE, should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 39171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39171

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mrs Sarah Hinler

(a) RESIDENCE No 1810 N Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John B Hinler

6 DATE OF BIRTH (month, day, and year) Oct 20, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Wm McCleester

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Biddison

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug 2, 1924, that I last saw h alive on Aug 2, 1924 and that death occurred, on the date stated above, at 9 20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Chronic nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of July 31, 1924

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E E Duncan, M. D.

8/2, 1924 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 8/5 1924

20 UNDERTAKER E J Fanning & Son, 1938 E Lafayette — ADDRESS

UG4 - 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89172

D 89172

CERTIFICATE OF DEATH.

188-006

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Echodale Ave nr Harford ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gus Blackwell

(a) RESIDENCE NO 575 Greenwillow St nr Penna Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept- 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Leonard Blackwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Kate Brent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Harry Blackwell (Bro)
(Address) 575 Greenwillow St

15 Filed AUG 4 - 1924 Robert P. Harrison Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broken neck & jaw
(Accidental-cave in of Bank while at work)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Pollitt, M. D.
(Coroner.)

8/2/24, 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va — DATE OF BURIAL 8-4 1924

20 UNDERTAKER David Easton — ADDRESS 976 Penna ave

16. WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89173

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 727 E. 41st ST.; WARD)

2-FULL NAME Mary E. Fowler

(a) RESIDENCE. NO. 727 E. 41st ST., 9th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert O. Fowler

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Virginia

PARENTS

10 NAME OF FATHER John Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co Virginia

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Virginia

14 Informant Wm. S. Fowler (Address) 727 E. 41st St.

15 Filed Aug 5 1924 Robert P. Harrison, Registrar

UG4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1924, to ....., 19..., that I last saw he alive on Aug. 2, 1924, and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. D. Greenstein, M. D.

Aug 5, 1924 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 5 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

Spec.—1-10-21—M&T—1500 Bks.

D 89174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Key

(a) RESIDENCE NO. 527 S. Charles St. ST., WARD Amelia Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 9, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10 NAME OF FATHER James Key

11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa

12 MAIDEN NAME OF MOTHER Freegie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant (Address) James Key 527 S Charles St.

15 Filed AUG 4 - 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1924, to Aug 4, 1924, that I last saw him alive on Aug 4, 1924, and that death occurred, on the date stated above, at 5 55 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) 2 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis (duration) 4 weeks yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign.

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Amelia Va

DATE OF BURIAL Aug 7 1924

20 UNDERTAKER F. A. Krause & Son

ADDRESS 763 Hanover St.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89175

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 733 E. Preston St., Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ann O'Dowd Cain

(a) Residence No. 733 E. Preston St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced [illegible] of (or) WIFE of James Cain

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 71 yrs. — mos. — ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, John O'Dowd

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Nancy Maynes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Miss Mamie Cain.

(Address) 733 E. Preston St.

15- Filed 8-4-1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 2nd. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 5, 1923 to Aug 2, 1924

that I last saw her alive on Aug 2, 1924

and that death occurred, on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the tongue.

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X ray, Signs + Symptoms

(Signed) Mary F. Foeglein M. D.

8. 4. 1924 (Address) 1028 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	....., 19....
20-UNDERTAKER.	**ADDRESS**
C.F.Evans & Son	118 W. Mt Royal Ave.

UG4

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 89176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 71-001

D 89176

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4823 Delaware Ave St., ... Ward) N M

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard A. Stafford

(a) Residence No. 4823 Delaware Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 15-1915

7-AGE. 9 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Kansas City Missouri

PARENTS.

10-NAME OF FATHER, John F. Stafford

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Rock Island Illinois

12-MAIDEN NAME OF MOTHER, Alice Mary Mulvey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) John F. Stafford

(Address) 4823 Delaware Avenue

15- Filed ..... 19.. 16- Robert P. Harrison, Registrar.

AUG 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 2-1924

17- I HEREBY CERTIFY, That I attended deceased from 5pm August 2 1924 to 10 pm Aug 2 1924

that I last saw h~~im~~ alive on Aug. 2 1924

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(Duration) ..... yrs. ..... mos. 5 ds. (Antemortem)

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Culture from Spinal Fluid

What test confirmed diagnosis?

(Signed) H. M. Stevenson M. D

, 19 (Address) 2733 N. Charles Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, Aug 5, 1924

20-UNDERTAKER M. Tuskey & Sons. ADDRESS 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

89177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89177.
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129

D 89177.
Registered No.....

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Wingo

(a) Residence No. Mount Hope Retreat St. 28th Ward

(Usual place of abode) Since May 15-24

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) abt 1846 (?)

7-AGE, abt 78 (?) yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (?) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unk

12-MAIDEN NAME OF MOTHER, Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), —

14- (Informant). Records of Mt Hope Retreat

(Address) Baltimore Md

15- —

Filed DEC 5 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 3. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15- 1924 to Aug 3 1924, that I last saw h. alive on Aug 3 1924, and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

abt (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (Duration) 4 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank F Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Sacred Heart — DATE OF BURIAL, Aug 5th 1924.

20-UNDERTAKER, John J Saltzgiver & Sons — ADDRESS 1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89178

CERTIFICATE OF DEATH.

31 89178

Registered No. D 89178

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Jones

(a) Residence No. 100 N. Front st. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

04-0

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Joseph Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Eliza Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed AUG 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 21 1924 to July 29 1924

that I last saw him alive on July 29 1924

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) J. F. White M. D.

7-30 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart	Aug 5th 1924.
20-UNDERTAKER.	ADDRESS
John J Fahey & Sons	1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89179

CERTIFICATE OF DEATH.

113 D 89179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 S Charles ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam B Rockmaker

(a) RESIDENCE. NO. 917 S Charles ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5. 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER T. Franklin Rockmaker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Emma Goldenberg

13 BIRTHPLACE OF MOTHER (city or town) Bath
(State or country)

14 Informant T. Franklin Rockmaker
(Address) 917 S. Charles St

15 Added

AUG 5 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 2, 1924, that I last saw her alive on Aug 2, 1924, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Entero Colitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Aug 2, 1924 (Address) 837 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	8/5/24 19

20 UNDERTAKER Fred G Krause & Son ADDRESS 703 Hanover St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

$8.63 ✓

D 89180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89180

100-00189180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Flamm

(a) RESIDENCE NO. 1440 Patapsco ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Franklin Flamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Municipal Hospital Records
(Address)

15 Filed AUG 5 - 1924 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2 192x

17

I HEREBY CERTIFY, That I attended deceased from 5-7, 192x, to 8-2, 192x, that I last saw him alive on 8-2, 192x, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis

(duration) 9 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude A. Howard, M. D.

8-3, 192x (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 5 1924.
20 UNDERTAKER	ADDRESS
F. A. Kraudt & Son	703 Hanover St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8918 I

CERTIFICATE OF DEATH.

129

D 8918 I

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 Hanover ST., WARD

2-FULL NAME Thomas Polk

(a) RESIDENCE NO. 893 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co

PARENTS

10 NAME OF FATHER Asbury Polk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Cooke

(Address) 813 Hanover

15 AUG 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3/24

17 I HEREBY CERTIFY, That I attended deceased from July 27/24 to Aug 3/24, 19....

that I last saw him alive on Aug 1/24, 19.... and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Miliary Tuberculosis

Antecedent cause (duration) one week yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Nephritis

Antecedent cause (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Bloll, M. D.

Aug 3 1924 (Address) 1203 Eye

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 5 1924

20 UNDERTAKER Wm W. Close & Son — ADDRESS 400 Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 89182

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1415 Edmondson Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Inez V Haller

(a) Residence No. 1415 Edmondson Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Aug 3-24

7-AGE. ..... yrs. ..... mos. 1 day If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto (State or Country) Md.

PARENTS.

10-NAME OF FATHER, Louis Haller

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Inez Charles

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Md

11- (Informant) Louis V. Haller

(Address) 1415 E. Edmondson Ave

15- AUG 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 4 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1924 to Aug 4 1924

that I last saw h alive on Aug 4 1924

and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Premature birth

7 months child

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Very Fatal at birth

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward A Morgan M. D.

, 19 (Address) 1322 Harlem Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem. Frederick Md.	Aug 5 1924
20-UNDERTAKER.	ADDRESS
William W. Shriver	1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 D 89183

REGISTERED NO.

1-PLACE OF DEATH
D 89183
CITY OF BALTIMORE: (No.) 1131 Penna ave ST.; (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Stewart

(a) RESIDENCE. No. 1131 Penna ave ST., WARD
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Wm M Long

11 BIRTHPLACE OF FATHER (city or town) Down Dount.
(State or country)

12 MAIDEN NAME OF MOTHER Ada Stewart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Ada Stewart
(Address) 1131 Penna ave.

15 Filed AUG 5 - 1924 19 ROBERT V. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1924, to Aug 3, 1924, that I last saw h.. alive on Aug 3, 1924, and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

, 19 (Address) 610 N. Fremont ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 4 1924
20 UNDERTAKER	ADDRESS
Samuel Kressley	1378 Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ACCURATE is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Interment
35-4B Chestnut Hill

D 89184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 89184

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE. (No. 2025 Maryland Ave St., ... Ward 12

2-FULL NAME Emma L. Faulkner

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2025 Maryland St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

4-SEX: Female — 4-COLOR OR RACE: White — 5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov-20-1877

7-AGE, 47 yrs. 8 mos. 14 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country): Bay Virginia

PARENTS.
10-NAME OF FATHER: James S. Faulkner
11-BIRTHPLACE OF FATHER (city or town) (State or Country): New Orleans
12-MAIDEN NAME OF MOTHER: Sydney A Faulkner
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Bay Virginia

14-Informant: Esther Faulkner
(Address) 2025 Maryland

15-Filed ..... 192 ..... Robert P. Harrison, Registrar.

AUG 5 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 4 1924

17- I HEREBY CERTIFY, That I attended deceased from June 18 1924 to Aug 4 1924
that I last saw h. alive on Aug 4 1924
and that death occurred, on the date stated above, at 11 10a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R B Norment M. D
8.4 1924 (Address) 336 Chestnut Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug 6 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89185 D 89185

CERTIFICATE OF DEATH.

1113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Plain View Road St. 26 Ward) Plain View Road

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Joseph Walker

(a) RESIDENCE. No. Plain View Road St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S

6 DATE OF BIRTH (month, day, and year) Feb. 26-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Beer.

PARENTS

10 NAME OF FATHER Charles H. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aberdeen Md.

12 MAIDEN NAME OF MOTHER Julia Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Beer.

14 Informant (Address) Charles H. Walker Plain View Rd.

15 Filed AUG 5 - 1924 19 ROBERT N. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4. 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2. , 1924 , to , 19 , that I last saw him alive on Aug. 2. , 1924, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Intest. Diarrhea

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Do not Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General sign.

(Signed) D. C. Talbott M. D.

8/4 - 1924 (Address) 116 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Aug 5 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 89186

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Arlington Ave. ST., 10 WARD)

2-FULL NAME Sarah Thomas

(a) RESIDENCE NO. 917 N. Arlington Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Thomas

6 DATE OF BIRTH (month, day, and year) April 23, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Landcaster Co. Va.

PARENTS

10 NAME OF FATHER Henry Nickens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Landcaster Va.

12 MAIDEN NAME OF MOTHER Matilda Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Landcaster Va.

14 Informant Geo. Thomas (Address) 917 N. Alington Ave.

15 Filed ..... 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 19 24, to Aug. 3rd. 19 24

that I last saw her alive on Aug. 3rd, 19.....,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical ex...

(Signed) Walter J. Jackson, M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Co Va.	Aug 5 1924
20 UNDERTAKER Mrs Sar H. Dennis	ADDRESS 1303 Pleasant

Wm. E. Kelly

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 5 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89187 (1)

D 89187
REGISTERED NO.

1- PLACE OF DEATH

CITY OF BALTIMORE: (No. 2239 E. North Ave ST., (WARD)

(If death occurred in n hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel T. Cowley

(a) RESIDENCE NO 2239 E. North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eliza J. Cowley

6 DATE OF BIRTH (month, day, and year) Aug 15/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor-
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City, Md.

PARENTS

10 NAME OF FATHER John Cowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna French

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mrs. Lewis
(Address) 2239 E. North Ave

15 Filed ..., 192 ... Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency
(Asthma-prob. Cardiac)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility-(struck by auto May 28/24-shock) (duration) yrs. mos. ds.

(Signed) ..., M. D.
(Coroner.)

8/4/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 5 192 4

20 UNDERTAKER W. S. Marshall ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. PHYSICIANS mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

89188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lakewood & Fayette ST., (WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Bender

(a) RESIDENCE No 405 N Bellwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J Bender

6 DATE OF BIRTH (month, day, and year) April 19/1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Knitter of hosiery
(b) General nature of industry, business, or establishment in which employed (or employer) 1886
(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa.
(State or country)

PARENTS

10 NAME OF FATHER Henry H Bender

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Anna E Lefevre

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John L. Bender
(Address) 405 Bellwood Ave

Filed Aug 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hopewell Cem. Port Deposit Md — DATE OF BURIAL Aug 6 1924

20 UNDERTAKER Harry R. Annacott — ADDRESS 4204 Ridgewood Ave

U. S.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89189

CERTIFICATE OF DEATH.

49

D 89189

REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Newton Jefferson Baylor

(a) RESIDENCE NO. Middle Brook, Augusta Co. Virginia.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Roberta Baylor

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

1886

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs. Laura Clemmer Middlebrook Va

15 Filed AUG 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to Aug. 4, 1924, that I last saw him alive on Aug. 4, 1924, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

carcinoma prostate

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Middle Brook, Va.

Did an operation precede death? yes. Date of June 30, 1924.

Was there an autopsy? no

What test confirmed diagnosis? Microscopical Examination

(Signed) Cayleux Faulkner, M. D.

8-4, 1924 (Address) Church Home Bg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middlebrook Va	Aug 5, 24
20 UNDERTAKER	ADDRESS
Wm Fleckner Sons	North Pa.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered EXACTLY. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN'S should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89190

CERTIFICATE OF DEATH.

D 89190

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 N. Stirling St ST., WARD)

2-FULL NAME Pauline Jones

(a) RESIDENCE NO 644 N Stirling ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 1 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Willis Sals

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mamie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Margaret Lola
(Address) 644 Stirling

15 Filed AUG 5 - 1924 192 Robert P. Harris, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gastro-intestinal Indigestion (duration) ... yrs. ... mos. ... ds.

(Signed) J S H Keller, M. D.
(Coroner.)

8/5/24, 192 (Address) 508 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery — DATE OF BURIAL Augs 1924

20 UNDERTAKER Mrs M. Elliott — ADDRESS 1725 Archland Ave

N.B.—NAME, NUMBER, etc., carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and undertaker's information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89191 D 89191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1236 Brentwood Ave St., Morrell Park Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Wm F Bennett

(a) Residence No. 1236 Brentwood Ave St., Morrell Park Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie J Bennett

6-DATE OF BIRTH (month, day and year) June 4 1859

7-AGE, 65 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brick Mason

(b) General nature of industry, business, or establishment in which employed (or employer) 012

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Bennett

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Susan Yellowley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington

14- (Informant Annie J Bennett) (Address) 1236 Brentwood Ave

15- Aug 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 3 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to Aug 3 1924

that I last saw him alive on Aug 2 1924

and that death occurred, on the date stated above, at 1 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Same

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo L McKeffer M. D.

Aug 4 1924 (Address) 2320 Hall Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	Aug 6 1924
20-UNDERTAKER. George Smith	ADDRESS 1532 Hollins

OG5

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89192

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Westerman

(a) RESIDENCE NO Delta, York Co., Pa. ST., WARD Delta Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. C. Westerman

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Napoleon Westerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Waggoner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Christopher Westerman
(Address) Delta, Pa.

Filed AUG 5 1924 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/24 19

17 I HEREBY CERTIFY, That I attended deceased from July 29 1924 to Aug. 5 1924.

that I last saw h/M alive on Aug. 5 1924,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 6 mos ✓ ds.

CONTRIBUTORY (Secondary) Acute card. dilatation (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Geo A Waggoner, M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta Pa.	8-5 1924
20 UNDERTAKER Earl B Hake 115 E Main St	ADDRESS

MARGIN RESERVED FOR FILING DATA—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89193

D 89193

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital Lombard St ST., WARD

2-FULL NAME Benjamin Oed

(a) RESIDENCE No. 18 Cherry gro Belmar Bel Air Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Hanna Oed

6 DATE OF BIRTH (month, day, and year) April 9 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Oed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not remembered

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Wm. Brandt

(Address) 13 Cherry Ave. Belmar

15 Filed AUG 5 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28 1924, to Aug 4 1924, that I last saw him alive on Aug 4 1924, and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Pyloric Obstruction

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 30

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Aug 6 1924

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89194

D 89194

CERTIFICATE OF DEATH. X 74-002

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Abraham Herman

(a) RESIDENCE No. Reisterstown Md. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby. 23, 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Daniel Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rena Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Carrie Herman (Address) 1917 Eutaw Place

15 AUG 5 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to Aug. 4, 1924.

that I last saw him alive on Aug. 4, 1924,

and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & Lab.

(Signed) Isidore J. Levy M. D.

Aug. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	8/6/1924

20 UNDERTAKER David Sondheim ADDRESS 112 W. Mt Royal Ave

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89195

D 89195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Plymouth Hall Madison Ave & Allendale St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Greenebaum

(a) RESIDENCE NO. Plymouth Hall Madison Ave & Allendale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman H. Greenebaum

6 DATE OF BIRTH (month, day, and year) July 1 1838

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Munich Germany

PARENTS

10 NAME OF FATHER Jonas Peter Germany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Peter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Isaac L. Greenebaum Plymouth Hall

15 AUG 5 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to August 4, 1924,

that I last saw her alive on August 4, 1924,

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation & fibrilation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Chas C. Judd, M. D.

, 19 (Address) 1701 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bnai B'rith Cemetery	8/6 1924
20 UNDERTAKER	ADDRESS
J. Aphram & Co	1611 Madison Ave

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89196

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3513 Liberty Heights Ave St., 15 Ward.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME...Samuel Thomas Linton

(a) Residence No...3513 Liberty Heights Ave. St., 15 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? 71 yrs. 0 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha W. Linton

6-DATE OF BIRTH (month, day and year) July-21-1853

7-AGE, 71 yrs. 0 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....None

(c) Name of employer.....None

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Joseph Linton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not-Known Ireland

12-MAIDEN NAME OF MOTHER, Sarah Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not-Known Ireland

14- (Informant) Mrs. C. D. Hubbard (daughter)

(Address) 3513 Liberty Heights Ave.

15-

Filed AUG 5 - 1924 By Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 5/24

17- I HEREBY CERTIFY, That I attended deceased from April 30, 1922, to Aug-3-, 1924, that I last saw him alive on Aug-3-, 1924, and that death occurred, on the date stated above, at 10.25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

at least

20 years (Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) ...yrs...mos...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Sputum Examination

(Signed) Leslie N. Gay, M. D.

, 19 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Aug-6-24
20-UNDERTAKER STERLING & BROWN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. North Ave.

Burial Permit Clerk

A—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B—should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89197.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89197.

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 So Caroline St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Powell

(a) Residence No. 107 So Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cassie Powell

6-DATE OF BIRTH (month, day and year) June 18 1871

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore County

PARENTS.

10-NAME OF FATHER, Benj Powell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Katherine Arnold

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt Co Md

14- (Informant) Mary Powell

(Address) 107 S. Caroline St.

15- Filed AUG 5 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 3 24

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924, to August 3 1924, that I last saw h... alive on August 3, 1924 and that death occurred, on the date stated above, at 1 a. P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Joseph L. Valentine, M. D.

Aug 4, 1924 (Address) 14 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Mary's Cemetery — DATE OF BURIAL, Aug 6, 1924

20-UNDERTAKER, Edward Bryan — ADDRESS 1631 Orleans St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89198

CERTIFICATE OF DEATH.

58-001

D 89198

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Appleby Ave / M. Washington ST., WARD)

2-FULL NAME Mildred E. Welsh

(a) RESIDENCE NO. Appleby Ave. M. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 2-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	5	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John D. Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Estella Hooker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John D. Welsh

(Address) Appleby Ave

15 Filed AUG 5 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to Aug 4, 1924, that I last saw her alive on Aug 4, 1924, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Stenosis Malnutrition

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8/2-4

Was there an autopsy? No

What test confirmed diagnosis? - Blood test

(Signed) Wm J Kelly, M. D.

19 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug. 6 1924
20 UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd.

Burial Permit Clerk.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89199

CERTIFICATE OF DEATH.

129

D 89199

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) ST., (WARD)

2-FULL NAME Abraham Meyers

(a) RESIDENCE NO. 32 N. Bond ST., 5 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar-Maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Levine 1499 E. Bala. Av.

15 AUG 5 - 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug. 5, 1924, that I last saw h. im alive on Aug. 5, 1924, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. nephritis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor L. Fry M. D.

Aug. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Russdale burn	Aug 5 1924
20 UNDERTAKER	ADDRESS
Jac T Levine	1499 E. Bala. Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89200

CERTIFICATE OF DEATH. X 188-003

D 89200

1-PLACE OF DEATH

CITY OF BALTIMORE, No. St. Agnes Hospital St., WARD) No

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis E. Thomas

(a) RESIDENCE No 119 M. St - S.E. St Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Chas B. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Maud M. Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Harry McPhegett 1306 11th St. N.E.

15 Filed AUG 5 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. 10 hours ds.

CONTRIBUTORY (Secondary) Auto Accident

(duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.

Aug 5th 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington Mem. Pk.

DATE OF BURIAL Aug 5 1924

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

AUG 5 1924

8.—WRITE PLAINLY, WITH CARBON INK. mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 8920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8920

CERTIFICATE OF DEATH.

V29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1311 Webster St (St.) (Ward)

2-FULL NAME Thomas Connelly.

(a) RESIDENCE. No. 1311 Webster St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John M. Connelly
(Address) 1311 Webster St.

15 Filed AUG 5 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1924, to Aug 4, 1924, that I last saw h alive on Aug 4, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) Dr. Schultz M. D.

Aug 5 1924 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	8/6/24 19
20 UNDERTAKER	ADDRESS
Fred G. Krause & Son.	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89202

CERTIFICATE OF DEATH.

D 89202

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 N Carlton ST., WARD

2-FULL NAME Annie L. Savoy

(a) RESIDENCE NO. 1027 N Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nil

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Savoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Annie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co Md

14 Informant: Annie Savoy
(Address): 102 N Carlton St

15 Filed AUG 5 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to Aug 4, 1924

that I last saw her alive on Aug 4, 1924

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

19 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Aug 6 1924

20 UNDERTAKER: Wm H Clouse & Son

ADDRESS: 1400 Madison

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89203

CERTIFICATE OF DEATH.

160

D 89203

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1511 Marshall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Harry L. Loetz

(a) Residence No.... 1511 Marshall St., 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 4, 1924

7-AGE, ...yrs....mos. /....ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.... infant

(b) General nature of Industry, business, or establishment in which employed (or employer)....

(c) Name of employer....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herman A. Loetz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Anna Leisen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant)....Herman A. Loetz

(Address)....1511 Marshall St

15- Filed AUG 6 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1924 to Aug 5 1924

that I last saw h. alive on Aug 5 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. / ds.

CONTRIBUTORY (Secondary) Obstruction

(Duration) ....yrs. ....mos. / ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

Aug 6 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Aug 6 1924

20-UNDERTAKER, A. Howard Evans ADDRESS 38 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Makel

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89204

CERTIFICATE OF DEATH. X 87

D 89204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hosp ST.) (WARD)

2-FULL NAME Margaret Blanche Makel

(a) RESIDENCE NO. Harwood-Anne Arundel Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE: Years 14 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) for

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harwood Md.

PARENTS

10 NAME OF FATHER Geo Makel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harwood Md

12 MAIDEN NAME OF MOTHER Ella Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River Md

14 Informant (Address) Geo Makel Harwood Po Md

15 Filed AUG 6 - 1924 19.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/24 19

17 I HEREBY CERTIFY, That I attended deceased from 7/30/24, 19.... to 8/5/24, 19....

that I last saw h.e alive on 8/5/24, 19....

and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Scleroderma.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harwood Anne Arundel Co.

Did an operation precede death? No Date of

Was there an autopsy? ~~No~~ Yes.

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adam's Cem Harwood Md — DATE OF BURIAL: 8/7 1924

20 UNDERTAKER: E H B Parker & Son — ADDRESS: 92 West

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89205

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1801 E. 31st St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Garland

(a) Residence No. 1801 E. 31st St., 9 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Garland

6-DATE OF BIRTH (month, day and year) Aug. 2-1871

7-AGE. 53 yrs. 0 mes. 1 ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Detroit Mich.

PARENTS.

10-NAME OF FATHER. George H. Roessler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Maria Sachs.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Judge William J. Garland

(Address) 1801 E. 31st St.

15- AUG 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 3-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1924 to Aug 3rd 1924

that I last saw h. alive on Aug 3rd 1924

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Trauma with Convulsions

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Coroner

(Signed) G. F. Ries M. D

Aug 5, 1924 (Address) 24 S Bway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem. DATE OF BURIAL. Aug 6, 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/-001 D 89206

REGISTERED NO.....

1-PLACE OF DEATH Univ. Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD) 12

2-FULL NAME Harry M. Franklin

(a) RESIDENCE NO. 1518 Mill Road Rd ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie Franklin

6 DATE OF BIRTH (month, day, and year) June 14 1883

7 AGE: Years 41 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator

(b) General nature of industry, business, or establishment in which employed (or employer): Hand

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Franklin

(Address) 1518 Mill Road Rd

15 AUG 9 1924

16 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-1-24, 19..., to 8-4-24, 19...,

that I last saw him alive on 8-4-24, 19...;

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia.

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wm Lowe Jr, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Aug 9 19 24

20 UNDERTAKER: ORENOWETH & SON,

ADDRESS: 3617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89207

CERTIFICATE OF DEATH.

X 44 D 89207

REGISTERED No.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Hassler

(a) RESIDENCE No. Springrose Pa ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hassler

6 DATE OF BIRTH (month, day, and year) July 26. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer, Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) York County, Penna

PARENTS

10 NAME OF FATHER Jacob Hassler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Ernst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Warren W. Hassler Pa.
(Address) Stone Grove Pa.

15 Filed AUG 6 - 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 1924, to 8-5, 1924, that I last saw h[illegible] alive on Aug 5, 1924, and that death occurred, on the date stated above, at 11.55 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gastric atony

(duration) —yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 7-29-24

Was there an autopsy? +

What test confirmed diagnosis? X

(Signed) Max Cutler, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wolfe Cemetery West Manchester Penna

DATE OF BURIAL Aug 6 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89208

CERTIFICATE OF DEATH.

113 D 89208

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Alice Anna ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Otremba

(a) RESIDENCE NO. 1718 Alice Anna ST., WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 24

7 AGE — Years: | Months: 5 | Days: 8 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank Otremba

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Zinie Kotowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Frank Otremba 1718 Alice anna St

15 Filed: AUG 8 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 4, 1924,

that I last saw her alive on Aug 4, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 alice anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Aug 6 1924

20 UNDERTAKER: F.W. Ozazewski — ADDRESS: 1930 Eastern Av

Florence Drelewski

Spec.—1-10-21—M&T—1500 Bks.

D 89209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89209

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH Hull.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1347 Hall ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florentina Drileska

(a) RESIDENCE NO. 1347 Hall ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Aug 17 1913.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1 year	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mateusz Drilesski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Florentina Volynska

13 BIRTHPLACE OF MOTHER (city or town) Bromsawa (State or country) Poland

14 Informant Mateusz Drilesski

(Address) 1347 Hall St

15 Filed ..... 19.....

AUG 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5- 1924

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to August 4, 1924, that I last saw h. alive on August 4, 1924 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H Newmark Jr, M. D.

8-5, 1924 (Address) 722 E Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug. 6 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89210

CERTIFICATE OF DEATH.

113

D 89210

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 236 S. Wolfe St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank . Baduniec

(a) Residence No. 236 S. Wolfe St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec .1 1922

7-AGE,	If LESS than 1 day,
1 yrs. 8 mos. 3 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

*(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Tomas . Baduniec

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Stella. Wiczulis

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mr . Tomas . Baduniec

(Address) 236 S. Wolfe Street

15- AUG 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st 1924 to Aug 4th 1924

that I last saw h. alive on Aug 4th 1924

and that death occurred, on the date stated above, at 630 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Colitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart failure & asthenia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry A Rutkoff M. D

815 . 1924 (Address) 1623 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Aug. 6 1924

20-UNDERTAKER,	ADDRESS
Lahr & Weber	803 Bank

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89211

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH 706 Registered No.....

City of BALTIMORE: (No. Lakewood Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wm Lynch Jr.

(a) Residence No. 706 Lakewood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 3, 1924

7-AGE.	If LESS than 1 day,
.....yrs.....mos.....2..ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, George Wm Lynch

11-BIRTHPLACE OF FATHER (city or town) Jersey City NJ
(State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Elizabeth Gibbons

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country),

11- (Informant) George Wm Lynch Jr.

(Address) 706 North Lakewood Ave.

12- AUG 6 1924 ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 5 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 24 to Aug 5 24

that I last saw h[illegible] alive on Aug 5 24

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F. Kay M. D.

Aug 5 24 (Address) 801 N Kenwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel	Aug 6 1924
20-UNDERTAKER.	**ADDRESS**
August Pasek	721 North Glover Street

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89212

D 89212

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 E. Lexington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Hudgins

(a) RESIDENCE NO. 1308 E. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lena Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Hudgins

(Address) 1308 E. Lexington St

AUG 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1924.

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Aug 5, 1924,

that I last saw him alive on Aug 5, 1924,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough, Measles

Bronchial Pneumonia

Meningitis

(duration) Days Hours ds.

CONTRIBUTORY (Secondary) Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard A. Sabol, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Aug 6 1924

20 UNDERTAKER: Mrs Christian Miller — ADDRESS: 2334 Gilmore

MARGIN RESERVED FOR PERMANENT RECORD.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89213

CERTIFICATE OF DEATH.

74-001

D 89213

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5405 Park Heights Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie D. Meyers

(a) Residence No. 5405 Park Heights Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas F. Meyers Jr.

6-DATE OF BIRTH (month, day and year) Apr 18 1857

7-AGE. 67 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Thomas Adler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-Informant. Mr. Chas F. Meyers

(Address). 5405 Park Heights Ave

AUG 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 4 1924

17- I HEREBY CERTIFY, That I attended deceased from March 4 1924 to Aug 4 1924, that I last saw her alive on Aug 2 1924, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Apoplexy & Paresis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Paresis

(Duration) 1 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) R P Cannan M. D

8-6-, 1924 (Address) 1207 N Carlton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Aug 7 1924
20-UNDERTAKER.	ADDRESS.
Wm J Tickner & Sons	Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89214 — CERTIFICATE OF DEATH. — 129 — D 89214

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2131 Herbert St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Lee

(a) Residence No. 2131 Herbert St., ... Ward. .....
(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Lee

6-DATE OF BIRTH (month, day and year) May 12, 1861

7-AGE. 63 yrs. 2 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto Co

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS:
10-NAME OF FATHER, Stansbury
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md
12-MAIDEN NAME OF MOTHER, Susan Zellers
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Miss Maude Browne
(Address) 2206 N. Holly St

15- ROBERT R. KRAUTER, Registrar.
AUG 6 - 1924 192 Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Aug 4 1924
that I last saw h- alive on Aug 4 1924
and that death occurred, on the date stated above, at 9.45 P m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 0 yrs. 6 mos. ds.

If violent cause, state (1) Means of injury; and (2) whether accidental, suicidal or homicidal.

Was disease constitutional? No If operation, date of?

Did an operation precede death? No Date of?

Was there an autopsy? No Have you any further knowledge as to cause, time, manner or place of death? Patient did not know when last seen alive

What test confirmed diagnosis? Blood Pressure

Signed) H. L. Nelson M. D

8/5/24 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Aug 7 1924

20-UNDERTAKER. Wm J Tucker & Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89215

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129 D 89215

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1935 Edmonson Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Wright

(a) Residence No. 1935 Edmonson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Willard K. Wright

6-DATE OF BIRTH (month, day and year) May 27 1845

7-AGE. 79 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Coath

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Marie Buck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14-(Informant) Mrs Ella C Dunlap

(Address) 1935 Edmonson Ave

15-

AUG 6 - 1924

ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 3 1924

17- I HEREBY CERTIFY, That I attended deceased from July 23 19 24 to Aug 2 19 24

that I last saw h.. alive on Aug 2 19 24

and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) 9 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What ~~test confirmed diagnosis~~? Path. Report

(Signed) J. H. Garrison M. D.

7 5 24 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	Aug 6 19 24
20-UNDERTAKER.	ADDRESS
Jos Soerdens Son	217 S. Roy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89216

CERTIFICATE OF DEATH. 7H-001

D 89216

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1215 Annapolis Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Naser

(a) Residence No. 1215 Annapolis Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Married~~, Widowed or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 17 1864

7-AGE. 60 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Koefner

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Julia Abiller

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany

14- (Informant) Harry Nash

(Address) 2105 Washington Ave

15-

Filed..... 192

ROBERT R. KRAUTER
Registrar.

AUG 6 - 1924

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 5 1924

17- I HEREBY CERTIFY, That I attended deceased from July 15 19 24 to Aug 5 19 24

that I last saw h-r alive on Aug 4 19 24

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy (over)

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cunningham M. D.

Aug 5 1924 (Address) 3100 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine Park Cem	Aug 8, 1924
20-UNDERTAKER,	ADDRESS
for Joerdens Son	2178 Pace

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARY WASHINGTON ✓

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89217.4 D 89217.

CERTIFICATE OF DEATH.

1736

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Washington

(a) RESIDENCE NO. 2217 Brun (Bruny) St ST. Bay View Hospital WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Washington

6 DATE OF BIRTH (month, day, and year): Jan 8 1852

7 AGE: Years 72 Months 6 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Alice Jessup

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Records (Address): Johns Hopkins Hospital

15 AUG 6 - 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to Aug 4, 1924, that I last saw h[illegible] alive on Aug 4, 1924, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - benign

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Balto., Md

Did an operation precede death? Yes Date of Exp July 31

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Exam

(Signed) Warfield M Jenor M. D.

8/5, 1924 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL: Aug 7th 1924

20 UNDERTAKER: Harry L Wright ADDRESS: 2264 W Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89218

CERTIFICATE OF DEATH.

194 D 89218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 E Fairmount Ave ST., WARD)

2-FULL NAME Sarah Smith

(a) RESIDENCE NO. 1526 E Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND of~~ Unknown

6 DATE OF BIRTH (month, day, and year) Exact by unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Approx 60	—	—	1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) farm work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va Loudon Co

PARENTS

10 NAME OF FATHER Zacariah Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jennie Neyl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant: Elsie McDaniels (daughter)

(Address) 403 Wayson st.

15 AUG 6 - 1924 ROBERT B. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 3, 1924, that I last saw h[illegible] alive on Aug 3, 1924, and that death occurred, on the date stated above, at 1055 A.m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion (Sun)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis & Hypostatic Pneumonia (duration) yrs. mos.

18 Where was disease contracted if not at place of death? took sick while working on farm in Anundel Co.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R F Gruby, M. D.

, 19 (Address) 1124 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 6 1924

20 UNDERTAKER Robert F Williams

ADDRESS 15-15 McElderry st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 89219

D 89219

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Mrs. Hennie Stern

(a) RESIDENCE No. Belleview Apts 1414 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam A Stern

6 DATE OF BIRTH (month, day, and year) Feb 3 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Nsme of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Monnie Lazarus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Steinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Mrs. Hattie Rand

15 Filed AUG 6 - 1924 ROBERT R. KI Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/24

17 I HEREBY CERTIFY, That I attended deceased from 7/29/24 19 to 8/5/24 19

that I last saw h— alive on 8/5/24 19 and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows: Endocarditis, Myocarditis

7

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ? 1

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Holley

(Signed) H. W. Holley M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chet Sholam Cem DATE OF BURIAL 8/7/1924

20 UNDERTAKER David Sondheim ADDRESS 118-20 N. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89220

CERTIFICATE OF DEATH.

75-101

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 Eleanor ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rohlfing

(a) Residence No. 430 Eleanor ave St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fr. Rohlfing

6-DATE OF BIRTH (month, day and year) Nov. 22, 1852

7-AGE, 71 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Daniel Hammerbacher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Fr. Rohlfing

(Address) 430 Eleanor ave

AUG 6 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 25th, 1924 to Aug 5, 1924 that I last saw h.e.r. alive on Aug 4th, 1924 and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis of right side

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Duncan, M. D.

Aug 5, 1924 (Address) 5106 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL, Aug 7, 1924

20-UNDERTAKER Zirkelbach & Zirkler

ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89221

D 89221

CERTIFICATE OF DEATH. X 129

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME William De Use

(a) RESIDENCE NO. Belair Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 6 1924, 19 Robert P. HARTSON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to July 26 1924, that I last saw him alive on July 26, 1924, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
Arteriosclerosis
Myocardial Insufficiency (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hopkins M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 5 1924

ADDRESS

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89222

CERTIFICATE OF DEATH. 122-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3703 Edmondson Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William B Helbright

(a) Residence No. 3703 Edmondson Ave St., NW Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Helbright

6-DATE OF BIRTH (month, day and year) March 7/1844

7-AGE. 80 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. — Helbright

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. — Stindt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Elsie Helbright

(Address) 3703 Edmondson Ave

15- Filed AUG 6 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 27, 1924, to Aug. 5, 1924, that I last saw h. alive on Aug. 5, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Atrophic cirrhosis of liver

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms

(Signed) J. F. Schmidt M. D.

Aug. 5, 1924 (Address) 2226 Madison Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Aug 7, 1924
20-UNDERTAKER.	ADDRESS
Harry H Almacod	4204 Ridgewood Ave

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89223 ✓ D 89223

CERTIFICATE OF DEATH. 99-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 N. Mount ST.; WARD 15

2-FULL NAME Maggie Alberta Winkfield

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1419 N. Mount ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 26th 1923

7 AGE — Years: — Months: 7 Days: 10 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Henry Winkfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Eula Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City Md.

14 Informant Mrs. Eula Winkfield (Address) 1419 N. Mount

15 Filed AUG 6 - 1924 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 4th 1924, to Aug 5th 1924, that I last saw her alive on Aug 5th 1924, and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas. A. Bell, M. D.

, 19 (Address) 1721 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: 8/7/24

20 UNDERTAKER: Daniel Easton — ADDRESS: Pa Ave 916

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89224

CERTIFICATE OF DEATH.

159-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3038 Presstman St., Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Conaway

(a) Residence No. 3038 Presstman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) aug 5 1924

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or 5 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Clarence Conaway

11-BIRTHPLACE OF FATHER (city or town) Kirkwood (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Bessie Hofman

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md

14- (Informant) Clarence Conaway

(Address) 3038 Presstman

15- Filed ....., 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

UG6 —1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). aug 5-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1924 to aug 5 1924

that I last saw h.r alive on aug 5 1924

and that death occurred, on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(Duration) ....yrs. 002 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of.....

Was there an autopsy? W

What test confirmed diagnosis?.....

(Signed) J. Whitridge Straq M. D.

aug 6 1924 (Address) 719 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery — DATE OF BURIAL. Aug 6, 1924

20-UNDERTAKER. James Dignan Son — ADDRESS. Lovely Lane

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Leeman, 918 N. Patterson Park

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89225

CERTIFICATE OF DEATH.

31

D 89225

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 504 Franklin Terrace St., ... Ward) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry M Farley

(a) Residence No. 504 Franklin Terrace St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Apr 5, 1889

7-AGE. 35 yrs. 3 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager

(b) General nature of Industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer Stewart & Keith

9-BIRTHPLACE (city or town) (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER Charles H Farley

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12-MAIDEN NAME OF MOTHER Mary V McCulloch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

11- (Informant) Charles H Farley

(Address) 504 Franklin Terrace

15- Filed AUG 6 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 4. 1924

I HEREBY CERTIFY, That I attended deceased from July 1 1924 to Aug 4 1924

that I last saw him alive on Aug 4 1924

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 10 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Alvin B Leeman M. D

8/6/24 (Address) 918 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL, Aug 7 1924

20-UNDERTAKER, William Cook — ADDRESS 551 E North

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Ona M. Keech)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89226

CERTIFICATE OF DEATH.

117

D 89226

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp'l ST., WARD 11

2-FULL NAME Miss Ona M Keech.

(a) RESIDENCE NO. Maryland Gen. Hospital 705 Md Ave Cumberland Md. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3- 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Md. Gen. Hospital Cumberland Md.

9 BIRTHPLACE (city or town) Cumberland (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. A. Keech

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Rooney

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Ona Keech. (Address) 705 Md Ave Cumberland Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 6. 24

17 I HEREBY CERTIFY, That I attended deceased from 8. 2. 24, 19..., to 8. 6. 24, 19..., that I last saw h- alive on 8. 6. 24, 19..., and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) ... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Operating Peritonitis

(duration) ... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-2-24

Was there an autopsy? No!

What test confirmed diagnosis? Clinical

(Signed) Jno A Sonnenburg, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md

DATE OF BURIAL 8/6 1924

UNDERTAKER Chas F. Frane & Son

ADDRESS 118 W Royal ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Filed AUG 6 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

(Sophia Schuppert)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89227

D 89227

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Old York Road ST., WARD) If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Sophia Schuppert NEW FREEDOM, PA.

(a) RESIDENCE NO. 3417 Old York Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Schuppert

6 DATE OF BIRTH (month, day, and year) January 24th 1840

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
84	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Albert Stonesifer, (Address) 3414 Old York Road.

15 AUG 6 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) August 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17th 1924 to Aug 5th 1924.

that I last saw her alive on Aug 5th 1924.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Jesse W. Longstreth M. D.

8/7 1924 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery, New Freedom, Pa.

DATE OF BURIAL Aug. 7 1924.

ADDRESS

20 UNDERTAKER E. Wm. Offutt, Jr. 115 N. Harrison Lane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89228

CERTIFICATE OF DEATH. X 185

D 89228

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Pier 8 Locust Point. ST., WARD)

(If death occurred in a hospital or institution, give its name instead of street and number and fill out No. 18.)

2-FULL NAME William H. Moffett.

(a) RESIDENCE NO. Baker Ave. Parkville, Balto. Co. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed or divorced HUSBAND of Jeannette M. Moffett.

6 DATE OF BIRTH (month, day, and year) November 24, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician, 073

(b) General nature of industry, business or establishment in which employed (or employer) B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas C. Moffett

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Leonard.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md
(State or country)

14 Informant Jeannette M. Moffett. (wife)
(Address) Baker Ave. Parkville Balto Co.

15 AUG 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted.
Fracture of the Skull
Fall from an elevator loft.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Aug. 6, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	Aug 7 1924

20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89229

CERTIFICATE OF DEATH.

X 182

D 89229

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Acton's Park Brooklyn. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Green. (C)

(a) RESIDENCE NO. 108 W. York St. ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Robert Green. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sally Butts. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Robert Green. (C) father.
(Address) 108 W. York St.

15 AUG 7 - 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Drowning.
Wading in the water.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)
Aug 6, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL 8/7/24 192

20 UNDERTAKER M Doyle & Son ADDRESS 16 E. Lee St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89230

D 89230

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 252 N. Schroeder St. WARD 19

2-FULL NAME Wm A. Thomas

(a) RESIDENCE NO. 252 N Schroeder St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Cold	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30 / 24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Chas Thomas

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Brummel

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Sadie Thomas
(Address) 252 N. Schroeder St

AUG 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. H. Norton, M. D.
(Coroner.)

Aug 6 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Aug 7 1924

20 UNDERTAKER Brown & Freeland — ADDRESS 1149 Scheroder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. so that it may be properly classified. CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89231

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 58 E. Woodland Ave. (Ward) 11

2-FULL NAME Charles Newton Hughes

(a) Residence No. 38 E. Woodland Ave. St., Ward .....
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6-DATE OF BIRTH (month, day and year): July 22 1924

7-AGE, 0 yrs. 0 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS

10-NAME OF FATHER: Irvin D. Hughes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Dolda C. Marshall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

11- (Informant) Mr Irvin D. Hughes

(Address) 58 E. Woodland Ave

13- AUG 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1923 to Aug 5 1924

that I last saw h.. alive on Aug 5 - 24

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis,

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (Bronchopneumonia)

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles J Walls M. D

19 (Address) 2 W Belvedere Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. DATE OF BURIAL: Aug 7 1924

20-UNDERTAKER: Wm Flickinger Sons ADDRESS: Norristown Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

17352 D 89232 ✓ D 89232

CERTIFICATE OF DEATH.

126

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME James Pledge

(a) RESIDENCE NO. 1524 Smallwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Pledge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rena Fortney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records Johns Hopkins Hospital
(Address)

15 Filed AUG 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1924, to Aug 6, 1924, that I last saw him alive on Aug 6, 1924, and that death occurred, on the date stated above, at 4.50 P.m.

The CAUSE OF DEATH* was as follows:

Primary streptococcic peritonitis
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Meningitis (streptococcic) 6 hrs.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug. 1

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. A. Mead, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 8 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1456 W. North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spsc—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

89233

CERTIFICATE OF DEATH. 31 D 89233

Registered No.....

1-PLACE OF DEATH Municipal T.B. Hospital

City of BALTIMORE: (No.....) Bay View St., ... Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Griffin

(a) Residence No. 834 Hartford Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	black	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1899

7-AGE. 25 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Louis Griffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ga.

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ga

14- (Informant) Hospital records

(Address)

15. AUG 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. 1924

16-DATE OF DEATH (month, day and year). Aug 3rd

17- I HEREBY CERTIFY, That I attended deceased from March 31 19 24 to Aug. 3 19 24

that I last saw him alive on Aug 3 19 24

and that death occurred, on the date stated above, at 4 P— m.

The CAUSE OF DEATH* was as follows:

Advanced Pulmonary TB

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Path. findings

(Signed) J. F. White M. D.

, 19 (Address) M.T.H., Bay View

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cem DATE OF BURIAL. Aug 7 19 24

20-UNDERTAKER. Lord & Hensley ADDRESS 518 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89234

D 89234

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No.) 1013 Peach al St., ... Ward) 19B

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Ransom

(a) Residence No. 1013 Peach al St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Ransom

6-DATE OF BIRTH (month, day and year) Feb 23 - 1869

7-AGE, 55 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) Junk dealer
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Edmund Ransom

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Cecelia Smith

13-BIRTHPLACE OF MOTHER (city or town) Va

14- (Informant) Annie Ransom
(Address) 1013 Peach al

15- AUG 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8/4/24

17- I HEREBY CERTIFY, That I attended deceased from July 14 24, to Aug 4, 19 24,
that I last saw h.....alive on Aug 3, 19 24,
and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

8/5, 19 24 (Signed) Chas Bonwell, M. D. (Address) 920 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pikesville Cem DATE OF BURIAL, Aug 7, 19 24

20-UNDERTAKER, Saml L Hensley ADDRESS 1 Bolle

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89235

D 89235

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Patapsco St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Palm.

(a) Residence No. 1712 Patapsco St., Ward

(Usual place of abode) (If not in Baltimore, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Magdalina Spann

6-DATE OF BIRTH (month, day and year) Sept 23 1848

7-AGE. 75 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION-OF DISEASE.

(a)-Trade, profession, or particular kind of work Seamen

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. Elevr

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany.

14- (Informant) Mrs Charlotte Palm

(Address) 1712 Patapsco St

AUG 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-5-1924

17- I HEREBY CERTIFY, That I attended deceased from July 25 1924 to Aug 5 1924

That I last saw him alive on Aug 5 1924

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Duration yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Inflammation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Campbell M. D.

Aug 7 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem Co

DATE OF BURIAL. 8-8 1924

20-UNDERTAKER. E & B Harle

ADDRESS 115 E Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. So that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 89236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89236

CERTIFICATE OF DEATH.

100-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N. Fulton ST., ... WARD 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Harriett E. Clunet

(Residence in Baltimore: No. 805 N Fulton Ave S.... yrs., ... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Sex.~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb 27, 1847
(Month) (Day) (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John T. Harlow

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Charlotte Humphreys

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Victoria Hallowes

(Address) 805 N Fulton Ave

15-
Filed AUG 7 - 1924, 191.. ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1924, to Aug 5 1924, that I saw her alive on Aug 4 1924, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Primary)
(Duration) ..... yrs. ..... mos. 8 .... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry L. Dodd M. D.

Aug 6, 1924 (Address) 735 N. Fulton.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 8—7.., 1924

20-UNDERTAKER, Geo. Hale — ADDRESS 115 E West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89237 ✓ D 89237

CERTIFICATE OF DEATH.

1731 49

REGISTERED NO.....

1-PLACE OF DEATH Johns Hopkins Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME George G Traut

(a) RESIDENCE NO. 1829 E North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Mar 31 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) #

(c) Name of employer #

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Traut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Freda Karlton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records Johns Hopkins Hospital

(Address) Baltimore Md

Filed AUG 7 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 5, 1924, that I last saw him alive on Aug 5, 1924, and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of mediastinum

(duration) ..... yrs. 3½ mos. ..... ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Exclusion diagnosis.

(Signed) N. H. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 8 1924

20 UNDERTAKER Jas E Kistler — ADDRESS 2334 Jeffries

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89238

CERTIFICATE OF DEATH.

113

D 89238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

2-FULL NAME Conrad Baumgartner

(a) RESIDENCE No 1602 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Nov 21/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	15	

8 OCCUPATION OF DEGEASED
(a) Trade, profession or particular kind of work: XXXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.Md

PARENTS

10 NAME OF FATHER: Conrad Baumgartner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.Md

12 MAIDEN NAME OF MOTHER: Charlotte Sadler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.Md

14 Informant: Mrs. Charlotte Baumgartner (Address) 1602 E. Hoffman

15 Filed AUG 7 - 1924 192 Robert P. Harrison, Registrar (Burial Permit Clerk)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): AUG 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro- intestinal

Indigestion (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. J. Waller, M. D. (Coroner.)

8/6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 7 1924

20 UNDERTAKER: Henry Storch Son — ADDRESS: 1301 E Eager St

Cor.—1-12-23—M&T—100 Bks.

D 89239 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89239

CERTIFICATE OF DEATH.

74-004

REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 W. Nathan St., WARD)

2-FULL NAME Maurice J. Hanahan

(a) RESIDENCE NO. 1737 W. Nathan St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work clerk. 109
(b) General nature of industry, business, or establishment in which employed (or employer) (Balto city Hall)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Maurice Hanahan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Davis

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Margaret Hanahan
(Address) 1737 W. Nathan.

15 Filed AUG 7 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Aug 6, 1924 (Address) 210 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Aug 8 1924

20 UNDERTAKER Robt J. Turner Sons — ADDRESS 412 S Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 89240

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., ... WARD)

2-FULL NAME Theodore DYPSKI

(a) RESIDENCE NO. 2824 Dillon St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Oct 8/1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... child .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER Julius Dypski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Katie Puda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant Julius Dypski (Address) 2824 Dillon St

15 Filed AUG 7 - 1924 192 ..... Registrar Robert P. Harrison Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Intracranial Hemorrhage
(Automobile accident, Inquest to held Aug 6/24

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Watkins, M. D.
(Coroner)

Aug 6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem Dept. DATE OF BURIAL 1924

20 UNDERTAKER Stephen F. Kalkowski ADDRESS 1021 Spring Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89241 | HEALTH DEPARTMENT—CITY OF BALTIMORE | D 89241

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 N. Chester St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Christian

(a) Residence No. 515 N. Chester St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of: Kate Sallie Christian

6-DATE OF BIRTH (month, day and year): Feb 6/53

7-AGE: 71 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Citizens Nat Bank
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Christian

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs W. G. Roberts
(Address): 515 N. Chester

15- Filed AUG 7 - 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 8/5/24

17- I HEREBY CERTIFY, That I attended deceased from May 15 19 24 to August 5 19 24
that I last saw h. alive on August 4 19 24
and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and arterial hypertension

(Duration) 4 yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(Duration) ..... yrs. ..... mos. 11 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical Examination and Urinalysis

8/6, 1924 (Signed) Albert Gespulkp M D
(Address) 1827 East North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL, 8/7, 1924

20-UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89242

D 89242

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1014 N. Stricker ST., WARD) 10

2-FULL NAME Dicy Williams

(a) RESIDENCE NO. 1014 N. Stricker ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bryant Williams

6 DATE OF BIRTH (month, day, and year) Dec 25-63

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	60	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Jerry Bryant

11 BIRTHPLACE OF FATHER (city or town) Ga.. (State or country)

12 MAIDEN NAME OF MOTHER Harriet Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Ga (State or country)

14 Informant Bryant Williams (Address) 1014 N. Stricker.

15 Filed AUG 7 1924, 19 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 31 1924, to Aug 7 1924, that I last saw h alive on Aug 6 1924, and that death occurred, on the date stated above, at 2.1 m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) O. J. Culman M. D.

19 (Address) 1036 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Valdosta Georgia | DATE OF BURIAL Aug 7 1924

20 UNDERTAKER Hand & McCaskey | ADDRESS 1400 Madison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89243

CERTIFICATE OF DEATH.

185- D 89243

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Charles & Barre Sts. ST., WARD)

2-FULL NAME Joseph Walas.

(a) RESIDENCE NO. 2202 E. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~late WIFE of~~ Anan Walas.

6 DATE OF BIRTH (month, day, and year) January 15, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Die setter. Federal
(b) General nature of industry, business, or establishment in which employed (or employer) Tin Decorating Co.
(c) Name of employer 022

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Walas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Rozalia Sumor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Anna Walas. (wife). (Address) 2202 E. Pratt St.

15 Filed AUG 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of skull & spine.
Accidental fall down elevator shaft.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Aug. 7, 1924 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus aug

DATE OF BURIAL 8 1924

20 UNDERTAKER John McAbee 1803

ADDRESS Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89244

CERTIFICATE OF DEATH. 118002 D 89244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST., WARD)

2-FULL NAME Miss Lydia Kerber

(a) RESIDENCE No. 2032 Cliftwood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Jacob F. Kerber

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md (State or country)

12 MAIDEN NAME OF MOTHER Anna M. Stoss

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Miss Lydia Kerber. (Address) 2032 Cliftwood Ave

15 Filed AUG 6 1924, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to Aug 5, 1924, that I last saw her alive on Aug 5, 1924, and that death occurred, on the date stated above, at 6.00 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (Intussusception)

Appox.

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Leucocytosis Anemia Nephritis

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 3, 24 Aug 4, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) no Attendance, M. D.

, 19 (Address) My Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Aug 8 1924

20 UNDERTAKER John Ulrich

ADDRESS 2915 Ereans

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89245

CERTIFICATE OF DEATH.

66

D 89245

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Jail. ST., ... WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert C. Cessna. alias Albert Mc. Monigal.

(a) RESIDENCE NO. Unknown. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Ethel Cessna.

6 DATE OF BIRTH (month, day, and year) June 20, 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Tyrone Pa.

PARENTS

10 NAME OF FATHER George W. Cessna.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Elizabeth Mc. Monigal.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Jacob S. Cessna. (brother).
(Address) 821 Crawford Ave Altoona Pa.

15 Filed ..... 192 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

AUG [illegible] 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism-

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Aug. 7, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R.C.

DATE OF BURIAL Aug 7 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89246 — CERTIFICATE OF DEATH. — D 89246

REGISTERED No. .....

1-PLACE OF DEATH Md General Hospital a.a. County

CITY OF BALTIMORE: (No. Church St. Extended ST., WARD .....)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Gischel

(a) RESIDENCE No. ~~Balto~~ a.a. County, Md ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie G. Gischel

6 DATE OF BIRTH (month, day, and year) March 5/892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32	4	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Brooklyn
(State or country) Md

PARENTS

10 NAME OF FATHER Wm G. Gischell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura C Bollman

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn
(State or country) Md

14 Informant (Address) Mrs Marie G Gischel Church St Rd near Light St Rd

15 Filed AUG 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

gun-shot wound of head.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) accidental

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Aug. 5, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL AUG 7 1924

20 UNDERTAKER John F Denny — ADDRESS 7152 Wash

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89247 D

CERTIFICATE OF DEATH. 46

D 89247

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.....ST.,.....WARD)

2-FULL NAME Esther Hirsh

(a) RESIDENCE NO. Hebrew Hospital ST.,.....WARD.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hebrew Hosp. Records (Address)

15 Filed AUG 7 1924 19 ROBERT N. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Aug. 6, 1924, that I last saw her alive on Aug 6, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; carcinoma of cervix ? (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidor S. Fury, M. D.

Aug 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 8 Aug 19

20 UNDERTAKER David Londeree

ADDRESS 1700 W. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89248

D 89248

CERTIFICATE OF DEATH.

194

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 817 Eastern Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John B Cuneo

(a) Residence No. 817 Eastern Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maria L. Cuneo

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE, 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, unknown.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14- (Informant) Mr. Felix Cuneo

(Address) 817 Eastern Ave

15- ROBERT N. KRAUTER

AUG 7 - 1924 Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 6 - 24

17. I HEREBY CERTIFY, That I attended deceased from August 5 ....., 1924, to August 5 ....., 1924, that I last saw h.. alive on August 5 ....., 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Prostration

..... (Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) John L. Valentine 2d M. D.

August 7, 1924 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem.	Aug 9 ....., 1924
20-UNDERTAKER	ADDRESS
John J. Cowan Son Chas F J Cowan	901 Holland St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

89249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 58-001 D 89249

MARGIN RESERVED FOR BINDING—B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 E. 34th ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. Armacost

(a) RESIDENCE NO. 823 E. 34th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Armacost

6 DATE OF BIRTH (month, day, and year): mch 4 1868

7 AGE — Years: 56. Months: 5 Days: 1. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wash D.C

PARENTS

10 NAME OF FATHER: Silas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Husband (Address)

15 Filed AUG 1 - 1924 ROBERT I. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-5 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to 8-5, 1924, that I last saw her alive on 8-4, 1924, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7/10/24

Did an operation precede death? Yes Date of 7/15/24

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Howard M. Bubert, M. D.

, 19 (Address) 2700 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Aug 8 - 1924

20 UNDERTAKER: John J. Cowan & Son Per F. J. Cowan

ADDRESS: 901 Hollins St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89250 ✓ D 89250

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 316 S. Woodyear St., Ward)

2-FULL NAME.. Patrick J. Hoban

(a) Residence No. 316 S. Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Hoban Deceased

6-DATE OF BIRTH (month, day and year) March 17

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Hoban

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Glynn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Catherine Hoban

(Address) 316 S. Woodyear St.

15- Filed AUG 7 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/6/24

17- I HEREBY CERTIFY, That I attended deceased from May 14 24 to Aug 6 1924

that I last saw him alive on Aug 6 1924

and that death occurred, on the date stated above, at 7.4 m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) T. H. Mantz M. D.

8/7/24, 19 (Address) 302 N. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL, Aug 8 19 24

20-UNDERTAKER John F. Cowan & Son per F. J. Cowan

ADDRESS 40 Hallam

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89251

CERTIFICATE OF DEATH. X74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2226 Callow Ave (St.) ..... (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B Freeman

(a) RESIDENCE NO. 2226 Callow Ave (St.) ..... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle B Freeman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 1445

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Isaman Isaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr Moreland 1013 N. Charles St.

15 Filed AUG 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Aug. 6, 1924, that I last saw him alive on Aug. 6, 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis, Chronic Bronchitis Disease (duration) several years

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Theodore H. Monson, M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebron Friendship Cemetery	Aug 8 1924
20 UNDERTAKER	ADDRESS
J. Ahearn & Co	1611 Madison Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89252 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 89252

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Johnson

(a) Residence No. 719 N. Bruce St., ... Ward 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer) B&O

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Carroll Co. Md

PARENTS.

10-NAME OF FATHER, Charles Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Municipal Hospital Records

(Address)

15- Filed AUG 7 - 1924 19.. Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-5-24

17- I HEREBY CERTIFY, That I attended deceased from 7-24, 1924 to 8-5, 1924

that I last saw him alive on 8-5, 1924

and that death occurred, on the date stated above, at 7 8 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis (Left Hemiplegia & Left Facial Paralysis). Syphilis.

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude A. Drace M. D.

8-6, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19..
Mt Auburn	8/7/24
20-UNDERTAKER, Daniel Easton	ADDRESS 716 Orleans

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89253 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 738 W Mulberry ST., (WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Pinkney

(a) RESIDENCE NO. 738 W Mulberry WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-21-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Howard Pinkney

11 BIRTHPLACE OF FATHER (city or town) McDaniel Talbot Co.
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Adams

13 BIRTHPLACE OF MOTHER (city or town) McDaniel Talbot Co
(State or country)

14 Informant (Address) Father.

15 AUG 7 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1924

17 I HEREBY CERTIFY, That I attended deceased from 8/3, 1924, to 8/6, 1924,
that I last saw h.. alive on 8/6, 1924
and that death occurred, on the date stated above, at 7 p. m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) portable pertussis (duration) Cardiac failure

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. L. Jackson M. D.

8/7 1924 (Address) 808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem

DATE OF BURIAL 8/7/24

20 UNDERTAKER David Easton

ADDRESS Pr

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 38

D 89254

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.... WARD)

2-FULL NAME Lillian Washington

(a) RESIDENCE NO. Granite Md ST., ... WARD Granite Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 20, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Carrie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): George Washington Granite Md

15 Filed AUG 7 -1924, 19.....

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/7/24 19

17 I HEREBY CERTIFY, That I attended deceased from 8/3/24, 19..... to 8/7/24, 19.....

that I last saw her alive on 8/7/24, 19.....

and that death occurred, on the date stated above, at 3.10 A.m.

The CAUSE OF DEATH* was as follows:

Syphilitic Meningitis

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bur. St. Alphonsus Cem

DATE OF BURIAL: Aug. 9 1924

UNDERTAKER

ADDRESS: Easton Doms Elliott City

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 89255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89255

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 Brunt St. ST., (WARD)

2-FULL NAME George H. Hines

(a) RESIDENCE NO. 1911 Brunt St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda J. Hines

6 DATE OF BIRTH (month, day, and year) April 1, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Collector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. T. Hines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna E. Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Amanda J. Hines
(Address) 1911 Brunt St.

15 Filed ..... 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

AUG 7 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~it~~ (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs., ... mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhoids ?

(duration) ? yrs. ? mos. ? ds.

(Signed) J. T. Hennessey, M. D.
(Coroner.)

Aug. 5, 1924 (Address) 288 Cumberland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cushen Cemetery	Aug 8 1924
20 UNDERTAKER	ADDRESS
Wm. R. A. Elliott	1715 Eutaw Pl

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39256

CERTIFICATE OF DEATH.

74-101

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 612 Wyeth st St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Conrad Erbe

(a) Residence No. 612 Wyeth st St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Magdalena Erbe

6-DATE OF BIRTH (month, day and year) Oct 27 1850

7-AGE. 73 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 1-10

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Conrad Erbe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germy

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germy

14- (Informant) Mrs Katie Thobe

(Address) 612 Wyeth st

15- Filed AUG 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 6 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to Aug 6 19 24

that I last saw him alive on Aug 6 19 24

That death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Supervened 3 days after Bronchial asthma.

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

8/6 (Signed) Raymond J. French M. D.

8/6, 19 24 (Address) 1707 Eutaw pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Aug 9 1924

20-UNDERTAKER, Jos Jordan & Son

ADDRESS 217 S. Pace

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89257

CERTIFICATE OF DEATH. 11-002

D 89257

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1332 Myrtle ST., WARD 7)

2-FULL NAME Rufus Deshields

(a) RESIDENCE NO. 1332 Myrtle ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Deshields

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 37 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter (Labor)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 140

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Deshields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Lindas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Rufus Deshields

15 Filed AUG 7 - 1924, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 — 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 — 1924, to Aug 5 — 1924

that I last saw him alive on Aug 2 — 1924

and that death occurred, on the date stated above, at 1130 A. M.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

(Address) 203 E. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 8/7/24

20 UNDERTAKER: F. C. Gorter — ADDRESS: 1405 McElderry

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death may be necessary. See instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89258

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1206 Whatcoat ST., ... (WARD)

2-FULL NAME Theodosia Ramsey

(a) RESIDENCE NO. 1206 Whatcoat ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sidney Ramsey.

6 DATE OF BIRTH (month, day, and year) ~~August 6 1924~~ unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer self

9 BIRTHPLACE (city or town) Franklin Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) unknown.

14 Informant Daughter in law (Maria Holland)
(Address)

15 Filed AUG 7 -1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. ....., 19.23, to 8-5-, 1924.

that I last saw her alive on August 5, 1924,

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Cardio nephritis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank Saunders, M. D.

, 19 (Address) 133 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Aug 8 1924
20 UNDERTAKER	**ADDRESS**
Mrs James H. Dennis	1503 Pressman St

Cor.—1-12-23—M&T—100 Bks.

Theodore K. Burzynski.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89259

D 89259

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1119 Binney ST., ... WARD)

2-FULL NAME Theodore K. Burzynski

(a) RESIDENCE NO. 1119 Binney ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) April 23 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Salt Lk City
(State or country)

PARENTS

10 NAME OF FATHER Stephen Burzynski

11 BIRTHPLACE OF FATHER (city or town) Salt Lk City
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Trocka

13 BIRTHPLACE OF MOTHER (city or town) Salt Lk City
(State or country)

14 Informant Stephen Burzynski
(Address) 1119 Binney St

15 Filed AUG 7 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFeeley, M. D.
(Coroner.)

Aug 7, 1924 (Address) 702 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Aug 8, 1924

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann

AUG 7 1924

FOR.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89260

D 89260

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 N Eutaw St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Brown alias Charles Johnson

(a) Residence No. 714 N Eutaw St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cole N.

6-DATE OF BIRTH (month, day and year) Nov 28 1853

7-AGE. 70 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Bicycle Repairer

(b) General nature of Industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country): N. Y.

PARENTS

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14- (Informant) Mrs. Cole N. Brown

(Address) 714 N. Eutaw

15-

Filed AUG 7 - 1924 192 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 6 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to Aug 5 1924, that I last saw him alive on Aug 6 1924 and that death occurred, on the date stated above, at 12-30 Noon.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ordema of the Lungs

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Exam of urine

(Signed) Robt J Slater M. D

8-6-1924 (Address) 126 Ensworth St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug. 8, 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 902 E N Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(address Mill Hollow)

D 89261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89261

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Sakowski

(a) RESIDENCE NO. 72 Mill Hollow, Hillsdale N.J. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 19, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Peter Sakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Minnie Wilkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records (Address)

15 Filed AUG 7 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-29, 1923 to 8-6, 1924

that I last saw her alive on 8-6, 1924,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Glioma)

(duration) 10 yrs. mos. days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-8-15

Was there an autopsy? No

What test confirmed diagnosis? Operation + Lab.

(Signed) Claude C. Hirst, M. D.

8-6, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cathedral — DATE OF BURIAL Aug 9 1924

20 UNDERTAKER Wm Cook — ADDRESS 1020 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89262 ✓

D 89262

CERTIFICATE OF DEATH.

X 47

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.; WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion E Mitchell

(Residence in Baltimore: No. Fullerton, Md St.; yrs. 5 mos. ..... da.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

NOTE—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 14 (Month) (Day), 1850 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas. Westbrey

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Harriet Kinsey

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Hall

(Address) Fullerton Md

15- AUG 7 - 1924 Robert P. Harrison, 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from apr. 17 1924, to Aug. 5 1924, that I saw h[illegible] alive on Aug. 5 1924, and that death occurred, on the date stated above, at 9-25 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma R- breast.

(Duration) 1 yrs. 6 mos. — da.

CONTRIBUTORY (Secondary) Metastasis to lungs.

(Duration) — yrs. — mos. — da.

(Signed) Dudley P. Bowie M. D.

Aug. 5, 1924 (Address) 904- N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence Fullerton Md

19-PLACE OF BURIAL OR REMOVAL, Oakland

DATE OF BURIAL, Aug. 8, 1924

20-UNDERTAKER Tolson Coo[illegible] & Son

ADDRESS [illegible] E Lexington

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Bks.

D 89263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89263

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Fremont ST., WARD) 17

2-FULL NAME Henry Willis

(a) RESIDENCE NO. 711 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 16-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Henry G Willis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Anderson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Elizabeth M Mahoblin
(Address) 711 N Fremont Ave

15 AUG 7 - 1924 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1923, to August 6, 1924,

that I last saw h alive on Aug 6, 1924,

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Davis, M. D.

, 19 (Address) 1009 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Mem

DATE OF BURIAL Aug 8 1924

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(Causey)

D 89264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89264

1-PLACE OF DEATH Aged Mens Home

Registered No.....

City of BALTIMORE: (No. 1400 W Lexington St., Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marshall Causey

(a) Residence No. 1400 W Lexington St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 20 1852

7-AGE, 74 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Carpenter & Bldg

(b) General nature of industry, business, or establishment in which employed (or employer)..... 12

(c) Name of employer.....

9-BIRTHPLACE (city or town). Carroll Co.
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Causey

11-BIRTHPLACE OF FATHER (city or town) Carroll Co Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Rose Ann Sturan

13-BIRTHPLACE OF MOTHER (city or town) Carroll Co. Md
(State or Country),

14-

(Informant) Mrs Blanche Fisher

(Address) 1400 W. Lexington St.

15-

Filed..... Robert P. Harrison, Registrar.

AUG 7 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 6 1924

17- I HEREBY CERTIFY, That I attended deceased from June 21, 1924 to Aug 6, 1924

that I last saw h alive on Aug 6, 1924

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Arteriosclerosis

Contributory (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

Arteriosclerosis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Jas L Trooper, M. D.

8/7, 1924 (Address) 341 E 20th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Aug 8, 1924
20-UNDERTAKER. George J Smith	ADDRESS 153 Hollins St

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

X

D 89265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89265

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1234 Delwood Avenue ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elzor Dowd

(Residence in Baltimore: No. 1234 Delwood Avenue St.; 13 yrs., 3 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH Unknown (Month), ... (Day), 1 (Year)

7-AGE, 53 yrs. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... saleslady
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Hardesty

(Address) 1234 Delwood Ave

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

AUG 7 - 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2nd (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Aug 7 1924 (Address) 3611 Reland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mehrle Cemetery, Elkridge

DATE OF BURIAL, Aug. 8, 1924

20-UNDERTAKER E. LeRoy Stafflen

ADDRESS 125 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89266

CERTIFICATE OF DEATH.

124

D 89266

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Nelson

(a) RESIDENCE No. 3911 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Nelson

6 DATE OF BIRTH (month, day, and year) Aug 6, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER J. Kirchenmeisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Kautz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Record.

15 AUG 7 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/24

17 I HEREBY CERTIFY, That I attended deceased from 7/16/24 19..... to 8/5/24 19..... that I last saw her alive on 8/5/24 19..... and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis (Gangrenous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? Yes Date of 7/17/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Signed) K. W. Hobby, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	8/9/24
20 UNDERTAKER	ADDRESS
Geo. A. Farley	Fulton & Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89267

CERTIFICATE OF DEATH. 161-001

D 89267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1727 McCulloh ST., WARD 11

2-FULL NAME Baby Harris

(a) RESIDENCE NO. 1727 McCulloh ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William S. Harris

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Va

12 MAIDEN NAME OF MOTHER Edna Reid

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country) N.Y.

14 Informant Edna Harris
(Address) 1727 McCulloh St

15 ..... 19..... Robert P. Harrison, Registrar

AUG 7 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Aug 6, 1924, that I last saw h e alive on Aug 6, 1924, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J. McRae, M. D.

8/6, 1924 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL

AUG 7 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89268

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD 11

2-FULL NAME Baby Duncan

(a) RESIDENCE No. 1105 Myrtle Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Augustus Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosie Duncan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Rosie Duncan
(Address) 1105 Myrtle Avenue

15 Aug 7 1924 Robert P. Harrison,
Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1924, to Aug. 7, 1924.

that I last saw h[illegible] alive on Aug. 7, 1924,

and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) M. Alexander Novey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Bureau of Health,

AUG 2 - 19

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 89269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 89269

CERTIFICATE OF DEATH.

34

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp ST., WARD) 4

2-FULL NAME: Fletcher Sullivan

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	8?		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) UNIVERSITY OF MARYLAND,

15 Filed ..... 19 ..... Registrar

AUG 7 - 1924

Robert P. Harrison,
~~Burial~~ Permit Clerk.

1666

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2/24 19

17 I HEREBY CERTIFY, That I attended deceased from 2/29/24, 19 ..... to 8/2/24, 19 .....
that I last saw him alive on 8/2/24, 19 .....
and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Tb. Osteitis of Spine

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tb. Meningitis

(duration) ..... yrs. ..... mos. 4. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) ..... M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 9 1924, 19

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89270

CERTIFICATE OF DEATH.

90 D 89270

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1570 McCulloh ST., WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Bundy

(a) RESIDENCE NO. 1570 McCulloh ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank Bundy

6 DATE OF BIRTH (month, day, and year) June 25 1849

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Edward C. Ridgley

(Address) 1570 McCulloch St

15 Filed AUG 7 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5. 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1924, to Aug 5th, 1924, that I last saw her alive on Aug 5th, 1924, and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Ridgley, M. D.

8/5, 1924 (Address) 924 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 8/8/24 19

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89271

D 89271

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 S. Bond ST., WARD) B

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Jesionowska

(a) RESIDENCE NO. 734 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23/1923

7 AGE Years ... Months 8 Days 14 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Jesionowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ludkadya Bontrowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Thos. Jesionowski

(Address) 734 S. Bond

15 AUG 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1924, to Aug 6 1924, that I last saw h alive on Aug 6 1924, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A F Ries, M. D.

Aug 7, 1924 (Address) 24 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary | DATE OF BURIAL 8/8 1924

UNDERTAKER Mrs Jackowski | ADDRESS 1118 Eastern

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89272 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89272

CERTIFICATE OF DEATH.

129 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2506 Hilldale Dr St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Royal E. Sibley

(a) Residence No..... 2506 Hilldale Dr St,.....Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Edna E. Sibley

6-DATE OF BIRTH (month, day and year) Dec 12th 1876

7-AGE 47 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER Eli Sibley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Younger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Edna E. Sibley

(Address) 2506 Hilldale Dr

15- Filed AUG 7 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924 to Aug 5, 1924

that I last saw him alive on Aug 5, 1924

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Hemiplegia from cerebral hemorrhage

May 18, 1924

(Duration) yrs. 7 (about) mos. ds.

CONTRIBUTORY (Secondary) Sudden cardiac failure — 2 minutes

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Krupp M. D.

Aug 6, 1924 (Address) 1002 W Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL. Aug 8th 1924

20-UNDERTAKER. H. B. Shepherd — ADDRESS 2236 Fredk Ave

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89273

CERTIFICATE OF DEATH.

100-001

Registered No. D 89273

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonia Benda

(a) Residence No. Bay View Asylum St., ... Ward ..... (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

NO

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H Brown

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 77 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Records
(Address) .....

15- Filed AUG 7 - 1924 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-6-24

17- I HEREBY CERTIFY, That I attended deceased from 8-4, 1924 to 8-6, 1924
that I last saw her alive on 8-6, 1924
and that death occurred, on the date stated above, at 1:00 a. m.
The CAUSE OF DEATH* was as follows:

Senile Retention

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Lab. & Autopsy

What test confirmed diagnosis? .....

(Signed) Claude D. Howe M. D.

8-6, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Aug 8, 1924
20-UNDERTAKER. Frank E Brack Son	ADDRESS 1906 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—5-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 89274

CERTIFICATE OF DEATH. X 3 VD 89274

REGISTERED NO. C.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N Eutaw ST.; WARD 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Watts

(Residence in Baltimore: No. 911 N Eutaw Suffolk Va St.; yrs. (6 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White Negro

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (write the word.) Single

6-DATE OF BIRTH, July (Month) 11 (Day), 1906 (Year)

7-AGE, 18 yrs. 27 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Custus Watts

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Diana Reburn

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Wilson

(Address) 911 N. Eutaw St.

15- Robert P. Harrison,

Filed....., 191..... Burial Permit Clerk. Registrar.

UG7 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 6 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/31 191..., to 8/5 1924, that I saw h[er] alive on Aug 5 1924, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Chron Pulmonary Tuberculosis Tuberculosis Laryngitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) yrs. 6 mos. ds.

(Signed) J. H. Williams M. D.

....., 191... (Address) 1240 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Suffolk Va.

19-PLACE OF BURIAL OR REMOVAL, Suffolk Va — DATE OF BURIAL, Aug. 8., 1924

20-UNDERTAKER Brown & Ferland — ADDRESS 114 N. Eutaw St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89275 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89275

CERTIFICATE OF DEATH. 122-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2608 Lehman St St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Heit

(a) Residence No. 2608 Lehman St St., 20 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Georganna E Heit

6-DATE OF BIRTH (month, day and year) Aug 1 1855

7-AGE,	If LESS than 1 day.
69 yrs. mos. 5 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New Freedom Pa

PARENTS.

10-NAME OF FATHER, Nicholas Heit

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Augusta Thompson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) James H. Heit

(Address) 2608 Lehman St

15- Filed AUG 7 - 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 6 24

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to Aug 6, 1924.

that I last saw h.. alive on 7-6, 1924.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Cerebrosis of Liver

Hypostatic Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos B. Hall M. D.

, 19 (Address) Halethorpe

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Park Cemetery	Aug 8, 1924
20-UNDERTAKER.	ADDRESS
Harry H Annacost	4204 Ridgewood Ave

MARGIN RESERVED FOR THE REGISTRAR

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89276

CERTIFICATE OF DEATH.

90

D 89276

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clarity

(a) RESIDENCE NO. 2807 Hillsdale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Clarity

6 DATE OF BIRTH (month, day, and year) Sept. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Anthony Clarity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary L Clarity 2807 Hillsdale

15 Filed AUG 8 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug - 2, 1924, to Aug 4th, 1924, that I last saw him alive on Aug 4th, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Appoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Manninger M. D.

Aug 4th 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenbaum Cemetery DATE OF BURIAL Aug 8 1924

20 UNDERTAKER J G Moran ADDRESS 300 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 89277
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 E. Lafayette ave., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Elisham

(a) Residence No. 1313 E. Lafayette ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, ~~or divorced~~ WIFE of (or) ~~HUSBAND~~ of William Elisham

6-DATE OF BIRTH (month, day and year) May 2nd 1858

7-AGE. 66 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Patrick Ford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Coleman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) J. E. Elisham

(Address) 1313 E. Lafayette st

15- AUG 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Aug 6 1924

that I last saw h[illegible] alive on Aug 6 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Heck M. D.

8/7 1924 (Address) 936 E. Monument st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

16-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Athol Cem. — DATE OF BURIAL. Aug 8th 1924

20-UNDERTAKER, J. J. Moran — ADDRESS 3000 E. Baltimore

Dr. Heck—936 E. Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89278

CERTIFICATE OF DEATH.

113 D 89278

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 231 E. Franklin ave. ST., WARD 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Harpenp

(a) RESIDENCE. No. 231 E Franklin ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ed. Harpenp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hannah Kitty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ed. Harpenp

(Address) 1701 Hanover St.

AUG 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Aug 7, 1924

that I last saw him alive on Aug 7, 1924

and that death occurred, on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. Campbell M. D.

Aug 7, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Aug 8 1924

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89279

CERTIFICATE OF DEATH.

31 D 89279

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 East St ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luvis Salafia

(Residence in Baltimore: No. 428 East St St.; 61 yrs. ..... mos. ..... ds.)

40 yrs in Baltimore 40 yrs in U.S.A.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word) Married

6-DATE OF BIRTH, Oct 29th (Month) (Day), 1859 (Year)

7-AGE 64 yrs. 9 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fruit Dealer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvatore Salafia

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Biaggia Fazzino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Salafia

(Address) 428 East St.

15- AUG 8 - 1924 ROBERT R. KRAUTER, Registrar.

FILED ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6- 24 (Month) (Day) (Year) 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1924, to Aug 6 1924, that I saw h.. alive on Aug 6 1924, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage & Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arno F. Block M. D.

Aug 7, 1924 (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, 8/8/24, 191...

20-UNDERTAKER George J. Puth ADDRESS 1725 Hanford Ave

N.B.—THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89280

CERTIFICATE OF DEATH. 159-102

D 89280

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilian M. Wirtz.

(a) RESIDENCE No. 3509 Chestnut Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 20, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	---	---	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lawrence V. Wirtz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Myrlie McCleary.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Lawrence M. Wirtz. (father)
(Address) 3509 Chestnut Ave.

15 AUG 8 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia, due to Laryngeal obstruction.

Patent Foramen Ovale.

(duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Bernhardt, M. D. (Coroner.)

Aug. 7, 1924 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Cemetery DATE OF BURIAL Aug 8 1924

20 UNDERTAKER CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89281

CERTIFICATE OF DEATH.

113

D 89281

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1022 (St.) W Saratoga ST., (Ward)

2-FULL NAME Georgianna Thompkins

(a) RESIDENCE NO. 1022 W Saratoga ST., WARD
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 9 1923

7 AGE — Years: 1 — Months: 4 — Days: 9 — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Nil
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James H. Thompkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mt Holly S C

12 MAIDEN NAME OF MOTHER: Lucy Ella Bryson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greenwood S C

14 Informant: James H. Thompkins
(Address): 1022 W Saratoga

15 Filed AUG 8 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Aug 7, 1924
that I last saw her alive on Aug 4, 1924
and that death occurred, on the date stated above, at 10.15A m.
The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) O. V. Hoerle M.D.
1924 (Address) 19 Harrellson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn Cem — DATE OF BURIAL: 8/8/24

20 UNDERTAKER: Dan'l Taylor — ADDRESS: 916 Cas

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89282

CERTIFICATE OF DEATH.

90 D 89282

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. 7th ST., WARD) 10

2-FULL NAME Ella Diggs

(a) RESIDENCE NO 208 S 7th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) Dec 31 1890 (Inquiry)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework (37)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home Salt City

9 BIRTHPLACE (city or town) (State or country) Salt City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Louis Diggs (Address) 208 S 7th St

15 AUG 8 - 1924 Registrar

Robert R. Krauter, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 1

(duration) yrs. mos. ds.

(Signed) James M Fenlon, M. D. (Coroner.)

Aug 7, 1924 (Address) 700 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Aug 8 1924

20 UNDERTAKER John Ullrich — ADDRESS 208 S Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

...tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

THIS IS A PERMANENT RECORD. Every item of infor...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Blks.

D 89283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-006 D 89283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., ... WARD) X

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Joseph Griffin. (C)

(a) RESIDENCE NO. 618 Ensor Street. ST., ... WARD 5

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. -- mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Nola Griffin. (C).

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Alex. Griffin. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Eliza Smith. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Nola Griffin. (C)(wife).
(Address) 618 Ensor Street

15 Filed AUG 8 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about chest. Accidentally caught under falling wall.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Rosshardt (Coroner) M. D.

Aug. 8th, 1924 (Address) 1014 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Accident Jay & Fallsway. August 6, 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Georges P C	aug 8 1924
20 UNDERTAKER Edward Bryon	ADDRESS 1631 orleans st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89284

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 155 D 89284

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ~~1339 Fremont Av~~ ST., R ✓ WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Dubb

(a) RESIDENCE NO. 1339 E. Fremont Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Dubb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Kanter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis, 1439 E. Balto St. (Address)

15 Filed ....., 19..... ROBERT R. KRAMER, Registrar

AUG 8 - 1924 Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 19 24

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 19 24, to Aug 8, 19 24, that I last saw him alive on Aug 8, 19 24, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

1 (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) 2 Gastroenteritis 2d (duration) yrs. mos. 6 ds.

3 Septicemia 2

18 Where was disease contracted if not at place of death? At home 5 days

Did an operation precede death? yes Date of Aug 4, 1924

Was there an autopsy? no

What test confirmed diagnosis? Agglutination & Culture

(Signed) Walter Landsman, M. D.

19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Wash. Road	Aug 6, 24
20 UNDERTAKER	**ADDRESS**
Jos. Lewis	1439 E. Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89285

CERTIFICATE OF DEATH.

113 D 89285

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Bruce ST., WARD) 17

2-FULL NAME Edwin F. Kane

(a) RESIDENCE NO. 317 S. Bruce ST., WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 20 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	F	11	15	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John G Kane

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country)

12 MAIDEN NAME OF MOTHER Genevieve M. Sumner

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant John J. Kane
(Address) 317 S. Bruce St

15 Filed AUG 8 - 1924 ROBERT D. KRAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Aug 6, 1924, that I last saw him alive on Aug 6, 1924, and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acidosis

Convulsions (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cookman M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug. 8 1924
20 UNDERTAKER	ADDRESS
George L. Schwartz	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89286

D 89286

CERTIFICATE OF DEATH.

118-102

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 N. Chester ST.: ..... WARD)

2-FULL NAME Pasquale Grilli

(a) RESIDENCE. NO. 1600 N. Chester ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~, or Divorced (write the word)
Male.	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 7, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Gilberto Grilli.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Mary Orlow.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Gilberto Grilli (Address) 1600 N. Chester St

15 AUG 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Aug. 7, 1924 that I last saw h... alive on Aug. 7, 1924 and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute toxemia.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? General Examination

(Signed) Chas. S. Nerstedt, M. D.

, 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8/9. 1924
20 UNDERTAKER George J Ruth	ADDRESS 1735 Hartford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89287

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 Gorsuch Avenue ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kinmitt

(a) RESIDENCE. NO. 517 Gorsuch Avenue ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if a foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Thomas Kinmitt

6 DATE OF BIRTH (month, day, and year) May 1st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Lennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Daisy Dunn

(Address) 510 N. 23rd St

15 AUG 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 1st 1923 to August 6th 1924, that I last saw he alive on August 6th 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus.

(duration) -1- yrs. 4 mos. — ds.

CONTRIBUTORY (Secundary) Chronic myocarditis

(duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? — no —

What test confirmed diagnosis? Clinical & microscopical

(Signed) Wm J Sullivan, M. D.

8/7. 1924 (Address) 1701 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 9 1924
20 UNDERTAKER	ADDRESS
E. A. Wiesefeld Jr	501 E 22nd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89288

CERTIFICATE OF DEATH.

113 D 89288

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Mosher ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Nelson

(a) RESIDENCE NO. 1418 Mosher St., WARD 16

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should also be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Infant)
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. E. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Irene Minor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Irene Nelson (Address) 1418 Mosher St.

15 Filed AUG 8 1924, 192.... Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said the (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Aug 7, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Aug 9 1924
20 UNDERTAKER Mrs W A Ellis	ADDRESS 1735 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D 89289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89289

CERTIFICATE OF DEATH.

43

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1902 Boone ST., (WARD)

2-FULL NAME Dr John T Houchens

(a) RESIDENCE NO. 1902 Boone ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annie C Houchens

6 DATE OF BIRTH (month, day, and year) Oct 16-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Doctor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Thomas F Houchens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Mary E. Suter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Address): Mrs Annie C Houchens 1902 Boone St

15 AUG 8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 2d, 1924 to Aug 7th, 1924, that I last saw him alive on July 20 —, 1924, and that death occurred, on the date stated above, at Noon m.

The CAUSE OF DEATH* was as follows:

Cancer of mouth

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. W. Fisher, M. D.

, 19 (Address) 1403 Linden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 9 1924
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

MARGIN RESERVED FOR BINDING.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89290

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 Gough Street St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances . Kendzior (Kedzior)

(a) Residence No. 1610 Gough Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 22 1908

7-AGE. 15 yrs. 7 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Stanislaus . Kendzior

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Maryanna . Polczynski

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Stanislaus . Kendzior

(Address) 1610 Gough Street

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 5th 1924, to Aug 6th 1924, that I last saw h.r alive on Aug 6th 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Fred. A. Rees per A. Fleis M. D

Aug 7th, 1924 (Address) 24 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. August 9 1924

20-UNDERTAKER, John McWeber — ADDRESS 1803 Bank st

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG8

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89291

CERTIFICATE OF DEATH.

90

D 89291

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John B. Carey.

(a) Residence No.... Preston & Valley Sts. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (~~Write the word.~~) Widower

5a-~~If married,~~ widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Agnes Beuty.

6-DATE OF BIRTH (month, day and year) 17 July 1850

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Krey.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), —

12-MAIDEN NAME OF MOTHER, Catherine Heek.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant)... Sister F. Constance

(Address).. Preston & Valley

15- Filed..... 192.....

Robert P. Harrison, Registrar.

AUG 8 - 1924 ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 8/24

17- I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to....., 19.....

that I last saw h~~im~~ alive on... Aug 3 ....., 1924.

and that death occurred, on the date stated above, at... 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

.....

Contributory.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. A. Warren, M. D.

Aug 8, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral	Aug. 9, 1924
20-UNDERTAKER,	ADDRESS
W. C. Weidefeld	914 Fremont Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

39292

CERTIFICATE OF DEATH.

57 D 89292

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Municipal Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank G. Idall

(a) RESIDENCE No. 2710 Parkwood ST., WARD 13

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcella M. Idall

6 DATE OF BIRTH (month, day, and year) Oct 8-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester Co., Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records

(Address) [illegible]

15 8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 - 7 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-23, 1923, to 8-7, 1924 that I last saw h[illegible] alive on 8-7, 1924 and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus - 10 yrs.
Hypertension; Chronic Nephritis;
Left Hemiplegia - 1 yr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Clyde S. Deane, M. D.

8. 7. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Statuary Corp Co	May 9 1924
20 UNDERTAKER	ADDRESS
W. J. Richardson	Baltimore

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S short statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG8

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89293

CERTIFICATE OF DEATH. X/26

D 89293

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD

2-FULL NAME Mrs. Anna Stoutenburgh

(a) RESIDENCE NO. 1128 Park Road ST., WARD R.d 9

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond B. Stoutenburgh

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	Jan	2,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulsr kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: J. Monroe-

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Hospital Record

(Address)

15 UG8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/8/24.

I HEREBY CERTIFY, That I attended deceased from 8/1/24, 19..... to 8/8/24, 19.....

that I last saw h alive on 8/8/24, 19.....

and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows: Peritonitis (Cause ?)

.....

.....

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of, over

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Wash. D.C.

DATE OF BURIAL: Aug. 1 1924

20 UNDERTAKER: Wm. W. Mears & Son

ADDRESS: 805 N. Calvert St.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89294

CERTIFICATE OF DEATH.

113

D 89294

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 Laurens St., Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leon Lecats

(a) Residence No. 1124 Laurens St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Sin

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 1 22

7-AGE, ...yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) Boy

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS

10-NAME OF FATHER, Walter Lecat.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Mary Lecats

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14-

(Informant) Mrs Walter Lecats

(Address) 1124 Laurens St

15-

Filed..... Robert P. Harrison Registrar.

G8 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 8/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Aug 8 1924

that I last saw h[im] alive on Aug 1 1924

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr William Files M. D

8/8, 1924 Address) 1928 Penna Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville DATE OF BURIAL, Aug 9 1924

20-UNDERTAKER, Samuel Gould ADDRESS 264 Main

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89295 D 89295

CERTIFICATE OF DEATH.

113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1310 N Carey St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josiama E Tillman

(a) Residence No. 1310 N Carey St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 1st 1924

7-AGE. ..... yrs. 7 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) City

(State or Country),

PARENTS.

10-NAME OF FATHER, Earl Tillman

11-BIRTHPLACE OF FATHER (city or town) City

(State or Country),

12-MAIDEN NAME OF MOTHER, Anna Thomas

13-BIRTHPLACE OF MOTHER (city or town) City

(State or Country),

14- (Informant) Mrs Anna Tillman

(Address) 1310 N Carey St

15- Filed AUG 8 - 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 8 1924

17- I HEREBY CERTIFY, That I attended deceased from August 3 1924 to Aug 8 1924

that I last saw h.. alive on Aug 7 1924

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Heat - Advanced

Pneumonia (Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observed

(Signed) W H Wright M. D.

Aug 8 1924 (Address) 1204 Orleans St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Kevorkian — DATE OF BURIAL: Aug 9 1924

20-UNDERTAKER: Samuel Coldfeld — ADDRESS: 1564 Mary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89296 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89296

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No.) 3911 Forest Park Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Joseph Zeltmann

(a) Residence No. 3911 Forest Park Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Catherine Hamburger

6-DATE OF BIRTH (month, day and year) June 19, 1836

7-AGE. 85 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar manufac Taylor & Marshall

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Lohne, Germany

PARENTS.

10-NAME OF FATHER, Franz Heinrich Zeltmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lohne, Germany

12-MAIDEN NAME OF MOTHER, Catherine Elizabeth Hillenberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lohne, Germany

14- (Informant) Henry Zeltmann (Son)

(Address) 3911 Forest Park Ave.

15- Filed AUG 8 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 6, 24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4 1924 to Aug. 6 1924

that I last saw him alive on " " 1924

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D

Aug 7, 1924 (Address) 2314 Mayfield Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. 8/9/24 19....

20-UNDERTAKER. Geo. J. Kelly ADDRESS 1735 Harford

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3

D 89297

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 863 N. Fayette St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Beatrice M. Goyette

(a) Residence No... 863 N. Fayette St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sidney Goyette.

6-DATE OF BIRTH (month, day and year) Oct 17th 1893

7-AGE, 30 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, Louis Collins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ky.

12-MAIDEN NAME OF MOTHER, Agnes Walden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ky.

14- (Informant) Mrs Agnes Doherty. (Address) 863 N. Fayette St.

15- AUG 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 6-1924

17- I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to Aug 6, 1924, that I last saw h[illegible] alive on Aug 6, 1924, and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (Duration) - yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Exam. Sputum

(Signed) Chas. C. Conser, M. D.

8-7, 1924 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Aug 9th, 1924

20-UNDERTAKER, Liston P. Russelburgh

ADDRESS 2620 St Paul St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89298

CERTIFICATE OF DEATH.

113

D 89298

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 722 N. Mount St., Ward 10) (If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME.... William Edw Dyson

(a) Residence No.... 722 N. Mount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col'd

5-Single, Married, Widowed, or Divorced, (Write the word.) Sgle

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Dec 30, 1923

7-AGE, ...yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Eugene Dyson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Ridgley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Eugene Dyson

(Address) 722 N. Mount St

15- 4069 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 3, 1924 to August 7, 1924, that I last saw him alive on August 6, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration)? yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Kidney Disease

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mac O'neill M. D.

Aug 8, 1924 (Address) 108 N. Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Auburn — DATE OF BURIAL, 8/9/24

20-UNDERTAKER. Daniel Carbin — ADDRESS 916 Ba ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89299 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D 89299

CERTIFICATE OF DEATH. 7/4-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. German Aged Home St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Nigey

(a) Residence No. German Aged Home St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar. 17, 1843

7-AGE. 81 yrs. 4 mos. 21 ds. — If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.
10-NAME OF FATHER, Christ Dauchet
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Eupnosina Dauchet
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) German Aged Home Records
(Address) Baltimore & Payson Sts.

15-Filed AUG 9 - 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 7, 19 24 to Aug 7, 19 24 that I last saw her alive on Aug 7, 19 24 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 10 hrs. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E Wells Hammond, M. D.

8-8-, 1924 (Address) 2000 Hollins Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Walbrook Cem	Aug 9, 1924

20-UNDERTAKER.	ADDRESS.
Joseph B Cook	1003 W Balto St

Spec—1-10-24—M&T—1500 Bks.

D 89300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89300

CERTIFICATE OF DEATH. 194

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ind. General Hosp ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Maloney

(a) RESIDENCE No. 607 N. Bradford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 2, mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1924

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
0	2 mos.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Maloney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Myrtle Hettenq

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs. Maloney 607 N. Bradford

15 Filed AUG 9 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to Aug. 7, 1924, that I last saw him alive on Aug. 7, 1924, and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Heat prostration

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Duppstein, M. D.

, 19 (Address) 1 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemtery — DATE OF BURIAL: Aug 9 1924

20 UNDERTAKER: Jno C. Miller — ADDRESS: 233 Hoffman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89301

CERTIFICATE OF DEATH.

90 D 89301

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E. 31st St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Henneman

(a) RESIDENCE NO 207 N. Patterson Park Ave WARD 9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Henneman

6 DATE OF BIRTH (month, day, and year) Feb/1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry G. Litz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A. Henneman
(Address) ~~207 N. Patterson Park Ave~~

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

AUG 3 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv. Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Cholicystitis-Gastro-intestinal Indigestion. ds.

(Signed) J. M. Walker, M. D.
(Coroner.)

8/9/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Aug 11 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

N.B.—WRITE PLAINLY, WITH ONLY ONE NAME IN EACH SPACE. THIS BLANK MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X41

89302

D 89302

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Nicholson

(a) RESIDENCE NO. Stevensville, Md. Co. Md. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 26 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Nicholson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Island, Md.

PARENTS

10 NAME OF FATHER Charles Rengal

11 BIRTHPLACE OF FATHER (city or town) Kent Island Md. (State or country)

12 MAIDEN NAME OF MOTHER - Rachel Henson

13 BIRTHPLACE OF MOTHER (city or town) Kent Island (State or country)

14 Informant Hospital Record. (Address)

15 AUG 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to Aug. 7, 1924.

That I last saw h alive on Aug 7, 1924; and that death occurred, on the date stated above, at 5.00 a. m.

The CAUSE OF DEATH* was as follows:

(1) Chronic Progressive muscular atrophy

(2) Hemiplegia Lateral sclerosis

(3) Kidney disease

(duration) yrs. 8 mos. 7 ds.

CONTRIBUTORY (Secondary) Septicaemia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Hemoglobin Sed & Gram

(Signed) W Wallace Walker, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevensville Md	8-9th 1924
20 UNDERTAKER	ADDRESS
E & B Hall	115 E Mont St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

89303

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

D 89303

CERTIFICATE OF DEATH

1-PLACE OF DEATH 1673 W. Milton Ave 90 REGISTERED NO. C.....

CITY OF BALTIMORE (No. 1673 ST.: W. Milton Ave WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank B List

(Residence in Baltimore: No. 1675 W Milton Ave S.S. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Apr 17, 1873 (Month) (Day) (Year)

7-AGE: 51 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Steamfitter
(b) General nature of industry, business, or establishment in which employed (or employer): 60

9-BIRTHPLACE (State or country): Balto.

PARENTS

10-NAME OF FATHER: Geo F List

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Mary Scherm

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. List

(Address) 2318 E. Madison St

15 AUG 9 - 1924, 191 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August 8, 1924 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 27, 1924, to August 8 1924, that I saw h[illegible] alive on August 8 1924, and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:
Valvular Disease Heart

(Duration) Heart Stroke yrs. mos. ds

Contributory (SECONDARY) Uremia (Duration) yrs. mos. ds.

(Signed) A Dorsey M.D.

, 191 (Address) Cor. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore | DATE OF BURIAL: Aug. 11, 1924

20-UNDERTAKER: Pickeler & Pickeler | ADDRESS: 1734 Eager St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 89304

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 E. Fort Ave St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Anna Blades

(a) Residence No. 709 E. Fort Ave St., 23 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 14, 1924

7-AGE. ....yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, William T. Blades

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Margaret Deal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md

14- (Informant) Margaret Blades
(Address) 709 E. Fort Ave

15- Filed AUG 9 - 1924 ROBERT R. [illegible] Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 8/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Aug 8, 1924

that I last saw him alive on Aug, 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell M. D.

Aug 8, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL, Aug 9, 1924

20-UNDERTAKER, A. Leland Evans ADDRESS 508 E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wojcech Mrowczynski,

D 89305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89305

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Aliceanna ST., 2 WARD)

2-FULL NAME Wojciech Mrowczynski

(a) RESIDENCE NO. 1724 Aliceanna ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1840-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Oyster Shucks

(c) Name of employer Pikes

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Tomas Mrowczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Francis Dlbrush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Marianne Mrowczynski

(Address) 1724 Aliceanna St

15 AUG 9 - 1924 ROBERT R. KRAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8 1924

17

I HEREBY CERTIFY, That I attended deceased from August 5, 1924, to August 8, 1924, that I last saw him alive on August 8, 1924, and that death occurred, on the date stated above, at 2 p- m.

The CAUSE OF DEATH* was as follows:

Myocarditis

2 weeks

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Relative Statement

(Signed) [illegible] M. D.

8.8. 1924 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	Aug 11. 1924.
20 UNDERTAKER	ADDRESS
W. F. Sadowski.	905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Blks.

D 89306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89306
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 Riggs Ave ST., WARD 16)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Bernard Hardesty

(a) RESIDENCE NO. 2612 Riggs Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Hardesty

6 DATE OF BIRTH (month, day, and year) Dec 22 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	67	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Md.

PARENTS

10 NAME OF FATHER Robert Hardesty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Cornelia Hardesty
(Address) 2612 Riggs Ave

15 Filed Aug 9 1924 ROBERT R. KRAUTER, Registrar
Burial Permit 10069

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to Aug 7, 1924, that I last saw him alive on July 20, 1924, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.
8 8, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carlton Cemetery	Aug 11, 1924
20 UNDERTAKER	ADDRESS
Edw. Leo & Son	E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89307

CERTIFICATE OF DEATH.

129

D 89307

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.) (WARD) X

2-FULL NAME Thaddeus Mabee

(a) RESIDENCE NO. 306 W. Saratoga ST., 4th WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 65 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 029

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ? Mabee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Hospital Record

15 Filed AUG 9 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/24

17 I HEREBY CERTIFY, That I attended deceased from 5/30/24, 19..., to 8/7/24, 19..., that I last saw h alive on 8/7/24 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) K. W. Haley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Aug 9 1924

20 UNDERTAKER STEWART & MOWEN COMPANY WILLIAM F. WOODEN, Successor — ADDRESS 108 N. Howard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 89308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89308

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E. Lanvale ST., WARD)

2-FULL NAME Mary A. Donahue

(a) RESIDENCE NO. 24 East Lanvale ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas J. Donahue

6 DATE OF BIRTH (month, day, and year): Feb. 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John McAuliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Honora Gallway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss Hannah G. McAuliffe 24 E. Lanvale Street

15 Filed AUG 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 9, 19..., that I last saw her alive on Aug 8, 1924, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Chronic Nephritis 5 yrs)

(duration) ... yrs. ... mos. 4 hrs. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

& Pneumonia (duration) ... yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Thos. F. Donaghy M. D.

8/9, 1924 (Address) 2032 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 8/12 1924

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 39309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hosp ST.: WARD

2-FULL NAME Elizabeth Cunningham

(a) RESIDENCE NO. 1903 Reed Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Cunningham

6 DATE OF BIRTH (month, day, and year) Sept 17 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Almore Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Tate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Cunningham

(Address) 1903 Wheeler Ave

15 AUG 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1924, to Aug. 8, 1924.

that I last saw her alive on Aug. 8, 1924,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(duration) 4 days yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8/8/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Armistead M. D.

, 19 (Address) 1017 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery Aug 11	1924
20 UNDERTAKER Sarah Sefer	ADDRESS 1600 N North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME John Wirth

(a) RESIDENCE NO. 174 E Hamilton ST., E Hamilton

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nov 7

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Wirth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Catherine Wasz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records (Address) John Hopkins Hospital

15 AUG 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Aug 8, 1924, that I last saw him alive on Aug 8, 1924, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left Kidney

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) P.O. Stroke

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8/8/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) F. H. Reinhoff, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Aug 11 1924

20 UNDERTAKER Josiah Syfer ADDRESS 1601 W North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89311

CERTIFICATE OF DEATH.

1/3 D 89311

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 98 Third Ave. Wagners Point St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Bialecki .....

(a) Residence No. 98 Third Ave. Wagners Point St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) April 19 1924

7-AGE.	If LESS than 1 day.
..... yrs. 5 mos. 20 ds.	..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Boleslaus Bialecki

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Stanislawa Cwiklinski

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country),

11- (Informant) Mr Boleslaus Bialecki
(Address) 98 Third Ave Wagn. Pt.

AUG 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 8/1924

I HEREBY CERTIFY, That I attended deceased from July 24 19 24 to Aug 8 19 24

that I last saw him alive on Aug 8 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Intercostalis

..... (Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY ~
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

, 19 (Address) 1 Brooklyn Ave Balto Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross A.A.Co.	Aug 9 1924
20-UNDERTAKER,	ADDRESS
John H. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Chapman

D 89312 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89312

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2441 Elting (St.;) (Ward) 15

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elza Chapman

(a) RESIDENCE. No. 2441 Elting St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edmund Chapman deceased

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home worke

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Keeley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Hackett

(Address) 2441 Eltg St

15 Filed AUG 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/3 1924 to 8/7 1924

that I last saw h alive on 8/5 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 4
Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. Knox Clutter, M. D.

8/8 1924 (Address) 2134 D St S.E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont Auburn Cemetery	August 10 1924
20 UNDERTAKER	ADDRESS
John H. Owens	538 Dolphin St

Spec.—1-10-21—M&T—1500 Bks.

D 89313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89313

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2129 Huntington Ave ST., WARD) W

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Auster Affelot

(a) RESIDENCE NO. 2129 Huntingdon Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Herman Affelot

6 DATE OF BIRTH (month, day, and year) Jan 28, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	73	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Janetzke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George W. Auster (Address) 1417 Willear Ave

15 Filed ..... 19..... Registered .....

Burial Permit Clerk.

AUG 9 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1924

17 I HEREBY CERTIFY, That I attended deceased from 6-6-, 1924, to 8-6, 1924, that I last saw h alive on 8-6, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: General Arteriosclerosis, Hypertension, Chronic interstitial nephritis, Chronic Myocarditis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis - decompensation (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Duncan C., M. D.

8-7, 1924 (Address) 6614 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Aug 9 1924

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important! See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

89314 17357

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X49 D 89314

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) .....

2-FULL NAME Martha Conley

(a) RESIDENCE NO. Barbourville Va ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of →

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Tom Conley

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Dora Morris

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Records Johns Hopkins Hospital
(Address)

15 Filed AUG 3 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to Aug 9, 1924, that I last saw he alive on August 9, 1924, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (malignant)

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) meningitis (Streptococcus)

(duration) ... yrs. ... mos. 17 ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of July 25-24

Was there an autopsy? Yes

What test confirmed diagnosis? Exam Path. Exam

(Signed) Warfield M Firor, M. D.

8/7, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barbourville Va — DATE OF BURIAL aug 9 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 224 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS DEPARTMENT RECORDS EXACTLY what information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89315

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

179

D 89315

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital . ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Cottman. (C).
also known as Fridrick Jones

(a) RESIDENCE NO. 1015 Rice Street. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced— HUSBAND of (or WIFE of) Kate Cottman. (C).

6 DATE OF BIRTH (month, day, and year) November 14 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Baker.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crisfield, Md.

PARENTS

10 NAME OF FATHER Upshur ~~Cottman~~ Jones. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Tayler. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mary Cottman. (C) (mother).
(Address) Whitestove Va.

AUG 9 - 1924

ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about chest and extremities.
Nebhritis, Hypostatia Pneumonia.
Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)
Aug, 9, 1924 (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Accident
2004 Edmondson Ave. June 21, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Whitestove Lancaster Co. Va.	8/10/1924
20 UNDERTAKER	ADDRESS
Thos. Geo. H. Holland	1631 Druid Hill

Cor.—1-12-25—M&T—100 Bks.

D 89316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 89316

CERTIFICATE OF DEATH. X 117

89316 D

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., WARD)

2-FULL NAME William Rhodes Jr W

(a) RESIDENCE NO. 2545 Yanetta ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apl 13-1907

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
17	3	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) at High School
(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country) New York

PARENTS

10 NAME OF FATHER William Rhodes

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) —

12 MAIDEN NAME OF MOTHER Grace Coleman

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country) New York

14 Informant Mrs L. A. Neil
(Address) 2545 Yanetta ave

15 Filed AUG 10 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute appendicitis (operation)

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York N. Y.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City New York	8/10/24
20 UNDERTAKER Chas. Weber & Son	ADDRESS 2503 Edmonson ave

B.—WHITE PEARL, WHITE UNRADIUM. INK—THIS DEPARTMENT RECORDS. ENTRY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89317 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89317

CERTIFICATE OF DEATH 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N Milton Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girata
434 N Milton Ave

(a) RESIDENCE NO. ~~434~~ Balt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6. 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Morris Girota

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Horwitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Morris Girota
(Address) 434 Milton Ave

15 Filed AUG 10 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Aug 8, 1924, that I last saw h[illegible] alive on Aug 8, 1924, and that death occurred, on the date stated above, at 11 45 P.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Edelman M. D.

, 19 (Address) 1904 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Below Mt Carmel	Aug 10 1924
20 UNDERTAKER	ADDRESS
S. Levin & Son	E Baltimore St

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89318

CERTIFICATE OF DEATH.

161-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. ..... ST., ... WARD) 5

2-FULL NAME Baby Slentz

(a) RESIDENCE NO. 2218 Lyndhurst Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Rubin Slentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Friedlander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Levine 1432 E Balto St.

15 Aug 10 1924 Robert P. Harrison, ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9- 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Aug 9, 1924,

that I last saw her alive on Aug 9, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isidore I. Fury, M. D.

Aug. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash. Road — DATE OF BURIAL: 8-10 1924

20 UNDERTAKER: Jos Levine, 1432 E. Balto — ADDRESS

AUG 10 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 89319

CERTIFICATE OF DEATH. 111-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., ... WARD)

2-FULL NAME Alice Jane Skipper

(a) RESIDENCE No 1626 Linden Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Harry Skipper

6 DATE OF BIRTH (month, day, and year) March 10/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Cold Spring
(State or country)

PARENTS

10 NAME OF FATHER Benj. Bowne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.Y.State

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Harry Skipper
(Address) ~~1626 Linden Ave~~

Filed AUG 10 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage -
Cirrhosis Liver

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Pallen, M. D.
(Coroner.)

8/10/24, 192 (Address) 568 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cheltenham Md DATE OF BURIAL 8/11- 1924

20 UNDERTAKER Wm J Tichnor Sons ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UG 1 01924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89320

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2432 E. Preston St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Garvey

(a) Residence No. 2432 E. Preston St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Garvey

6-DATE OF BIRTH (month, day and year) Dec 25th 1863

7-AGE, 60 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Pat Murray

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Margaret Garvey

(Address) 2432 E. Preston St.

15- Filed Aug 8 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 7/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st 1924 to Aug 7 1924

that I last saw h[illegible] alive on 11 3 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Heaver M. D.

8/10, 1924 (Address) 390 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Aug 11 1924

20-UNDERTAKER. ADDRESS

F. B. Hippert 1850 W. Balto St.

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 89321

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1328 N. Bond St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Rebecca Miller

(a) Residence No. 1328 N. Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John N. Miller

6-DATE OF BIRTH (month, day and year): May 25th 1861

7-AGE: 63 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John L Clarke

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Bertha E Edwards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14-

(Informant): Edward N. Miller

(Address): 1328 N. Bond st

15-

(Filed) AUG 10 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 9/1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4, 19 24, Aug. 8, 19 24, that I last saw h. alive on August 8, 19 24, and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: August 12th 1924

20-UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E. Monument st

8—WRITE PLAINLY, WITH UNFADING INK. Every question should be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89322

CERTIFICATE OF DEATH.

D 89322

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST. 2 WARD)

2-FULL NAME Mary B. Griffiths

(a) RESIDENCE NO. Oxford Ave. ST. Howard Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas G. Griffiths

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work File Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer New Amsterdam Casualty Co

9 BIRTHPLACE (city or town) Salem

(State or country) Md.

PARENTS

10 NAME OF FATHER Cornelius B. Long

11 BIRTHPLACE OF FATHER (city or town) Salem

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen A. Love

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Edward Long

(Address) 614 E 32 St

15 AUG 10 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Aug 8, 1924, that I last saw h er alive on Aug 8, 1924, and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Thyrotoxicosis

(duration) 2 yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Dyer M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accideutal, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Aug 11 1924

20 UNDERTAKER H. Sauder Sons — ADDRESS Pro Recd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89323

CERTIFICATE OF DEATH.

129

Registered No.....

D 89323

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 N. Broadway St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin J. Johnson

(a) Residence No. 1026 N. Broadway St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every NUMERICAL statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Sept 12 1848

7-AGE, 45 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ass't Postmaster

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) ..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER George W. Johnson

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Sarah A. Smith

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Virginia

14-(Informant) Lelia Whitney

(Address) 1627 N. Broadway

15-Filed AUG 10 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 8, 1924

17-I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to Aug 8, 1924, that I last saw h.. alive on Aug 8 1924 and that death occurred, on the date stated above, at 9h ..m.

The CAUSE OF DEATH* was as follows:

Nephritis (Bright's Disease)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Pericarditis

(Duration) ..... yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) R. Carroll Johnson M.D.

, 19 (Address) 1534 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cemetery | DATE OF BURIAL, Aug 12 1924

20-UNDERTAKER, Mrs R. A. Elliott | ADDRESS 25 Richland Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89324 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89324

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1317 E Madison St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Suggs

(a) Residence No. 1317 E Madison St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: Yrs. 35 mos. ..... ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), N.C.

PARENTS:
10-NAME OF FATHER, Isaac Suggs
11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.C
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.C

14- (Informant) Mary Suggs
(Address) 428 N Fabbett St

15- AUG 10 1924 Robert P. Harris Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 6-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924 to Aug 6, 1924
that I last saw him alive on Aug 6, 19.....
and that death occurred, on the date stated above, at 10 20 p.m.
The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

Hour (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heat Prostration

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Edward Fisher, M. D.

8-7, 1924 (Address) 1612 Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cemetery	Aug 11, 1924
20-UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1725 Eastland

THIS IS A PERMANENT RECORD—WRITE PLAINLY. USE UNFADING INK—This certificate must be completely and legibly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89325 | CERTIFICATE OF DEATH | 143-002 | D 89325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Pendleton

(a) RESIDENCE NO. 1463 N Gary ST., WARD Essex Co. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Pendleton

6 DATE OF BIRTH (month, day, and year): July 7 1906

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	July	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co Va.

PARENTS

10 NAME OF FATHER: Ruben Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co. Va

12 MAIDEN NAME OF MOTHER: Ida Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co Va

14 Informant (Address): Joseph Pendleton Essex Co. Va.

15 Date: AUG 7 0 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug-7-1924 to Aug-7-1924 that I last saw h alive on Aug 7-1924 and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Ectopic Pregnancy
Ruptured Tubes
Operation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Internal Hemorrhage

(duration) yrs. hrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug-7-24

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) S B Stigler M. D.

Aug 8. 1924 (Address) 1413 D. Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Essex Co. Va. Bollers Hill. | DATE OF BURIAL: Aug 10 1924

20 UNDERTAKER: Virginia A. Brooks | ADDRESS 1463 N. Gary St

MARRIAGE RECORD—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 89326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89326

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 827 Hamilton Terrace St., ... Ward) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Polk Pomeroy

(a) Residence No. 827 Hamilton Terrace St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If ~~married~~, widowed, or ~~divorced~~, of ~~the HUSBAND~~ of ~~the WIFE~~ of Eugene H Pomeroy

6-DATE OF BIRTH (month, day and year) November 28, 1845

7-AGE. 78 yrs. 8 mos. 19 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Charles Polk

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Dillingeha

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Helen M. Bowler

(Address) 827 Hamilton Terrace

15- Filed AUG 1 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 9 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to Aug 9, 1924

that I last saw h.. alive on Aug 8, 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis,

(Old Age)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured femur (over)

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Wm. J. Watson, M. D.

Aug 9, 1924 (Address) 2120 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Emmaton — DATE OF BURIAL, Aug 12 1924

20-UNDERTAKER, Howard K McKenna — ADDRESS Aberdeen

mar

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89327

D 89327

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Carroll St ST., ... WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Augusta Collison

(a) RESIDENCE No. 1235 Carroll St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Dec 4 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER George Glenn

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen Glenn

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant Wm H Collison
(Address) 1235 Carroll

15 FILED AUG 10 1924 19.....

Burial Permits Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8/ 1924

17

I HEREBY CERTIFY, That I attended deceased from 8/6/, 1924, to 8/8/, 1924,

that I last saw h[illegible] alive on 8/8/, 1924,

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thos Reed Dorsey, M. D.

....., 19 (Address) 1 W Read St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Aug 9 1924

20 UNDERTAKER William Cook — ADDRESS 508 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Weston E. Moore)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89328 D 89328

CERTIFICATE OF DEATH.

175

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205-McCulloh ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Weston E Moore

(a) RESIDENCE. NO. 1205 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
M	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): W.S.P.Co.

(c) Name of employer: Md

9 BIRTHPLACE (city or town) (State or country): Edmd Md

PARENTS

10 NAME OF FATHER Edmd Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Sorenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs. Moore 205 McCulloh

15 Filed 10 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1927 to Aug 7 1924 that I last saw h alive on Aug 7 1924 and that death occurred, on the date stated above, at 230 m.

The CAUSE OF DEATH* was as follows:

I Stomach Poison

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart Expand Condition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Southern

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Mellon M. D.

, 19 (Address) 1302 W North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis, Md.	Aug. 10 19 24
20 UNDERTAKER Jos. M. Johnson	ADDRESS 309 Dulaney

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89329 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 5 WARD)

REGISTERED NO. 198

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Ford

(a) RESIDENCE NO 608 Herbert Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown (N.C.)

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (Common)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Byron Wright
(Address) 1218 McElderry St

15 Filed AUG 11 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-stab wound thru rt. ventricle of heart (autopsy)

(Inquest to be hepd on Aug 11/24

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Paterson (Coroner.), M. D.

8/9/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel County — DATE OF BURIAL 8/11/24 1924

20 UNDERTAKER Byron Wright — ADDRESS 1218 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89330

CERTIFICATE OF DEATH.

135

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4010 Springdale Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. H. Raleigh

(a) Residence No. 4010 Springdale Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Raleigh

6-DATE OF BIRTH (month, day and year)

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-Informant) Mrs. H. F. Hartge

(Address) 4010 Springdale Ave

DEC 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 8 1924

17- I HEREBY CERTIFY, That I attended deceased from June 25 1924 to Aug 8 1924

that I last saw h. alive on Aug 8 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Prostatectomy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of June 25/24

Was there an autopsy? Yes No

What test confirmed diagnosis?

(Signed) A. J. Underhill M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Aug 11, 1924

20-UNDERTAKER. E. LeRoy Stifflen

ADDRESS 125 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89331 ✓

CERTIFICATE OF DEATH.

182 D 89331

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Off Pier #5 Pratt Street. ST., WARD)

2-FULL NAME Booker T. Spriggs. (C).

(a) RESIDENCE NO. 1111 Comet Street. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------.

6 DATE OF BIRTH (month, day, and year) July 6, 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	1	1.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Spriggs. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sarah E. Travers. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Sarah E. Travers. (C) aunt.
(Address) 416 Aisquith St

Filed AUG 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning, while in swimming.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Rennhard, M. D. (Coroner.)

Aug 9, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Aug 12 1924

20 UNDERTAKER Edw Bryan. ADDRESS 1631 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89332

CERTIFICATE OF DEATH.

113

D 89332

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 Orchard St. ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Colston

(a) RESIDENCE NO. 548 Orchard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

10 NAME OF FATHER Morris Colston

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Morris Colston
(Address) 548 Orchard St.

15 Filed ..... 192 ..... Registrar

AUG 11 1924 ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Henderson M. D.
(Coroner.)

Aug 11, 1924 (Address) 1202 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8/11 192 4

20 UNDERTAKER Dame Easton

ADDRESS 976 Pearl

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89333

CERTIFICATE OF DEATH.

113 D 89333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 E. 29th ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Carr

(a) RESIDENCE No 631 E 29th St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 14/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Howard A Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester Pa.

12 MAIDEN NAME OF MOTHER Edith Wrighton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard A.Carr
(Address) 631 E 29th St

15 Filed AUG 1 1924, 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition-Gastro-Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Carr (Coroner.), M. D.

8/9/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug 1/1924

20 UNDERTAKER William Cook — ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89334

CERTIFICATE OF DEATH. X 140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

2-FULL NAME Mary J. Franke.

(a) RESIDENCE NO. Pine Grove Ave. Raspeburg, Balto Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. None ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 9, 1908.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	10	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Franke.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Josephine Charvat.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Josephine Franke (mother)
(Address) Pine Grove Ave. Raspeburg

15 AUG 11 1924

ROBERT N. KRAUTER, Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage.
Chronic Endocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Aug, 9, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Pine Grove Ave. Raspeburg, Balto. Co. Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer, DATE OF BURIAL Aug 5 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89335

CERTIFICATE OF DEATH

151

D 89335 REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 35 N Ellwood Av St.: (C) WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles H. Gumple

(Residence in Baltimore: No. ~~35 N Ellwood Av~~ St.: 63 yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 25, 1861 (Month) (Day) (Year)

7 AGE: 63 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Harness
(b) General nature of industry, business, or establishment in which employed (or employer): Maker

9 BIRTHPLACE (State or country): City

PARENTS

10 NAME OF FATHER: Carl Gumple

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz Ring

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Gumple

(Address) 35 N Ellwood ave

AUG 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 9, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to, Aug 8 1924, that I saw h~~m~~ alive on Aug 8, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Gangrene of Leg

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY) Myocardial arterial Degeneration

(Duration) yrs. 6 mos. ds.

(Signed), Standish McCleary M. D.

Aug 10, 1924 (Address) 1609 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Cathedral Cemetery

DATE OF BURIAL: Aug 12, 1924

20 UNDERTAKER: John A Mc[illegible]

ADDRESS 3000 E. Balto St

Cor.—1-12-23—M&T—100 Bks.

D 89336

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

D 89336

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 641 Wolpert Ave ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Wm. Parlett
641 Wolpert Ave

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 27/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER George Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Viola Colwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Reba Fitzpatrick
(Address) 641 Wolpert Ave

15 AUG 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Contusion-compression
(Accidental, fell while playing &
struck head on cement pavement,
Aug 3/24) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) G. S. H. Colwell, M. D.
(Coroner.)

Aug 10/24 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 8/11/24

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU
TION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89337

CERTIFICATE OF DEATH.

90 D 89337

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2717 E Madison ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Scroggs

(a) RESIDENCE. No. 2717 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Almira Scroggs.

6 DATE OF BIRTH (month, day, and year): Sept 19th 1849

7 AGE: Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hoseler.

(b) General nature of industry, business, or establishment in which employed (or employer): Northern P. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Scroggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Almira Norris (Address) 2717 E Madison St

15 Filed AUG 1 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 19 24

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1924, to Aug 8, 1924, that I last saw h.. alive on Aug 8, 1924, and that death occurred, on the date stated above, at 5:55 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Dilated aorta.
Chronic Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma - arterio-sclerosis. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Louis H. Krumreine, M. D.

, 19 (Address) 722 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: Aug 11th 1924

20 UNDERTAKER: Leo. G. Crook

ADDRESS: North & Harford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89338

CERTIFICATE OF DEATH.

47 D 89338

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N Central Ave ST., WARD) 5

2-FULL NAME Hattie Foster

(a) RESIDENCE NO. 532 N Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced (or) WIFE of John Foster.

6 DATE OF BIRTH (month, day, and year) exactly unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	approx 61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer) and Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Henry Foster (son)

(Address) 532 N Central Ave

15 Filed AUG 1 1924 ROBERT R. KRAUTH, Burial Permit Clerk. Registrar

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1924, to Aug 9, 1924, that I last saw h[illegible] alive on Aug 8, 1924, and that death occurred, on the date stated above, at 3 A1 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast. 1 year 4 months

(duration)

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

, 19 (Address) 1429 N Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Aug 12 1924

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89339

CERTIFICATE OF DEATH.

90

D 89339

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3406 Elgin Ave ST., WARD)

2-FULL NAME Winfield Washington Roberts

(a) RESIDENCE NO. 3406 Elgin Ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or WIFE of)
Ida E. Roberts

6 DATE OF BIRTH (month, day, and year) Jan. 16th. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oyster Packer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER George Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachael Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ida E. Roberts
(Address) 3406 Elgin Ave

15 Filed AUG 11 1924 19 Burial Permit Clerk ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/24 19

17 I HEREBY CERTIFY, That I attended deceased from 8/9/24, 19.., to 8/9/24, 19.., that I last saw h.. alive on 8/9/24, 19.., and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:
Myocarditis — Dilitation & Hypertrophy

(duration) yrs. mos 14 ds.
CONTRIBUTORY (Secondary) arteri-sclerosis —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical

(Signed) Walter S. Niblett, M. D.
Aug 11/24 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 8/12/24 19

20 UNDERTAKER: H. E. Hughes 424 N Broadway — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89340

CERTIFICATE OF DEATH.

44 D 89340

1-PLACE OF DEATH Municipal Hospital (If not in a hospital or institution, give its NAME instead of street and number.) Registered No.

City of BALTIMORE: (No. Bay View Asylum St., Ward)

2-FULL NAME Jennie Gitomer

(a) Residence No. 20 North Chester St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1887

7-AGE. 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Bernard Jenn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Hospital Records
(Address) Bay View Asylum

15- Filed, 192 ROBERT A. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/10/24

17- I HEREBY CERTIFY, That I attended deceased from August 2 1924 to August 10 1924
that I last saw h.er alive on August 11 1924
and that death occurred, on the date stated above, at 2a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach c
General metastasis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Operative Shock

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? 20 N. Chester St.

Did an operation precede death? yes Date 3/ or/24 & 8/ /24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Wm. P. Champe M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holmes Herring	Aug 5th, 1924
20-UNDERTAKER.	ADDRESS
Jas T Lewis,	1439 E. Baltimore.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 1 1924

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89341

CERTIFICATE OF DEATH.

31

D 89341

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Upton ST., 17 WARD)

2-FULL NAME Frank Banks

(a) RESIDENCE NO. 1333 Upton ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maggie Banks

6 DATE OF BIRTH (month, day, and year) July 26, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
59	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 15 D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodland Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Woodland Md

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓ ✓

14 Informant Lula Banks

(Address) 1333 Upton St

15 Filed AUG 7 1924, 19 ROBERT F. KRAUTER, Burial Permit Clerk, Registrar

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8. 1924

17

I HEREBY CERTIFY, That I attended deceased from August 1924 to Aug. 8th 1924, that I last saw him alive on Aug. 7th 1924, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis meningitis

(duration) yrs. mos. ✓ ds.

CONTRIBUTORY (Secondary) Pul. Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 644 Smith St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

8/5, 1924 (Address) 92 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 11 1924
20 UNDERTAKER	ADDRESS
Mrs James H. Dennis	1303 Freestman St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89342

D 89342

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1314 N. Bruce St. WARD)

2-FULL NAME Ida May Tongue

(a) RESIDENCE NO. 1314 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Six yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nursing
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Forest. Md.

PARENTS

10 NAME OF FATHER Richard H. Tongue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Richard Tongue 1314 N. Bruce St.

15 Filed AUG 11 1924, 192 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) 2 E Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Centery

DATE OF BURIAL Aug 11, 1924

20 UNDERTAKER Mrs James H. Dennis

ADDRESS 1303 Pressman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

89343 1734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 17

2-FULL NAME Mary Hill

(a) RESIDENCE NO. 411 W Monument ST. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. 5 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Noah Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Irene Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Record Johns Hopkins Hosp (Address)

15 Filed AUG 11 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9, 1924

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1924, to August 9, 1924, that I last saw h[illegible] alive on August 9, 1924, and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ..... yrs. ..... mos. 14 ds. +

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A. A. Wreck, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 11 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 89344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89344

CERTIFICATE OF DEATH.

X 99-002

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Madison ave ST.; WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

2-FULL NAME Henry Blockman

(Residence in Baltimore: No. 1420 McCulloh St ; 3 yrs., 2 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, 8 (Month) 8 (Day) 1894 (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Base Ball Player
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). San Antonio, Texas

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Blanch Blockman

(Address) 1420 McCulloh St

15-

Filed ....., 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-28 1924, to 8-8 1924, that I saw him alive on Aug. 8 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. mos. ds.

(Signed) W. H. Montague M. D.

8-8, 1924 (Address) 225 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Texas

19-PLACE OF BURIAL OR REMOVAL. Texas Hillsboro Hillsboro

DATE OF BURIAL. 8/11/24

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89345

CERTIFICATE OF DEATH.

74-001

D 89345

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Ravenwood Av ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula V. Griffin

(a) RESIDENCE. No. 3142 Ravenwood Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas N. Griffin

6 DATE OF BIRTH (month, day, and year) Mch 28/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Gloucester Co Va

PARENTS

10 NAME OF FATHER Thomas R. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloucester Co Va

12 MAIDEN NAME OF MOTHER Ella F. Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gloucester Co Va.

14 Informant (Address) Mrs Frank Dehuff 3142 Ravenwood Av

15 Filed AUG 11 1924 19 ROBERT R. KRAUTER Burial Permit Clerk, Registrar

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1924, to Aug 10, 1924, that I last saw her alive on Aug 10, 1924, and that death occurred, on the date stated above, at 5-50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Cerebral Hemorrhage (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lemmon M. D.

8/10, 1924 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	8/13 1924
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89346

CERTIFICATE OF DEATH.

31 D 89346

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. #225 N. Castle St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Muller.....

(a) Residence No. #225 N. Castle St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 17th. 1877

7-AGE.	If LESS than 1 day.
47 yrs. mos. 21 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watch Maker

(b) General nature of industry, business, or establishment in which employed (or employer)..... Jeweler

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City.

PARENTS.

10-NAME OF FATHER. George Muller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germeny

12-MAIDEN NAME OF MOTHER. Louisa Lepper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs. Peter Fink

(Address) #221 N. Castle St.

ROBERT R. KRAUTER,

15-

Filed AUG 1 1924 19.. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 8th. 24

17- I HEREBY CERTIFY, That I attended deceased from March 1st 19.24 to Aug 7th 19.24

that I last saw h.r alive on August 7th 19.24

and that death occurred, on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arthemia + Heart failure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs + symptoms

(Signed) Jony A Rutledge M. D.

8/10 19 24 (Address) 1623 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Balto. Cemetery	8/11/24. 19....

20-UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89347

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

46 D 89347

Registered No.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. A. E. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rackensperger (Rackensperger)

(a) Residence No. 4012 Massachusetts Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of G. A. Rackensperger

6-DATE OF BIRTH (month, day and year) April 2, 1874

7-AGE. 50 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER John Zimmerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do

14-(Informant) Bay View Hospital

(Address) Baltimore, Maryland

15- AUG 11 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 9, 192x

17- I HEREBY CERTIFY, That I attended deceased from Aug 6, 192x to Aug 9, 192x

that I last saw h alive on Aug 8 192x

and that death occurred, on the date stated above, at 7 05 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Goldsmith M.D.

8-9-. 1924 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL. Aug 12 192x

20-UNDERTAKER Joseph B Cook ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89348

CERTIFICATE OF DEATH.

D 89348

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2320 Washington Blvd. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William E. Wilkins

(a) Residence No. 2320 Washington Blvd. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia H. Wilkins

6-DATE OF BIRTH (month, day and year) Nov. 4, 1865

7-AGE. 58 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Petersburg
(State or Country), Virginia

PARENTS.

10-NAME OF FATHER, William Wilkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Amelia H Wilkins
(Address) 2320 Washington Blvd.

15- Filed AUG 11 1924 ROBERT E. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to Aug. 8, 1924, that I last saw him alive on Aug 6, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

Valvular Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

8-8-, 1924 (Address) Washington & Hammonds Ferry Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, Aug 11", 1924

20-UNDERTAKER: Joseph B Cook ADDRESS: 1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gavell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89349 ✓ D89349

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Farrell

(a) RESIDENCE NO. 20 N. Mount ST., WARD 9

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Farrell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Egan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed AUG 11 1924, 19.. ROBERT A. KRAETER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/24, 19

17

I HEREBY CERTIFY, That I attended deceased from 8/5/24, 19.., to 8/9/24, 19..,

that I last saw h alive on 8/9/24, 19..,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

7

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Anemia Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ? Bon Secours Hospital

Did an operation precede death? Yes Date of 8/6/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Microscopical

(Signed) Kyle W. Holley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem | DATE OF BURIAL 8/11/1924

20 UNDERTAKER Frizzell Talbot Taylor | ADDRESS Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89350

D 89350

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Penna Ave ST., WARD 7

2-FULL NAME Emma May Bruning

(a) RESIDENCE NO. 2226 Penna Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE William Bruning

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Scheckels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant William Bruning

(Address) 2226 Penna Ave

15 AUG 11 1924 ROBERT S. KRAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/1924

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1924, to Aug 9, 1924.

that I last saw h[illegible] alive on Aug 8, 1924,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease

(duration) 5 yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) anemia

(duration) ✓ yrs. ✓ mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Lowe, M. D.

. 19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leadenhall

DATE OF BURIAL 8/12 1924

20 UNDERTAKER M Luckey & Son.

ADDRESS 1512 W North

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89351

39351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Tuberculosis Hospital, Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Dorsey (Viola Barnes)

(a) Residence No. 15 N. Bruce St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Black

5-Single, (Married) Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. of min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Virginia (State or Country),

PARENTS.

10-NAME OF FATHER, Richard Goode

11-BIRTHPLACE OF FATHER (city or town) Va (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Hospital Records

(Address)

15- Filed 192 Registrar.

AUG 11 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/9/24

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to Aug 9, 1924, that I last saw h[illegible] alive on Aug 9, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pott's Disease, Thoracic Vertebrae

Tuberculous Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. findings

(Signed) J. F. White M. D.

, 19 (Address) M. T. H. Bay View.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. 8/12/24

20-UNDERTAKER Dan Easton — ADDRESS 96 Cem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

August 11 - 1924

We the undersigned do hereby make oath in due form of Law that Viola Ford, also known as Viola Barnes is one and the same person.

Witness
W. R. Smith
Notary Public

Samuel Bailey Seal

Martha Bailey Seal

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 89352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 89352

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 41 Ayres Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Schaum

(a) Residence No. 4411 Liberty Heights St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

Corner Fulton Ave & Presstman St. City District

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schaum

6-DATE OF BIRTH (month, day and year) June 25-1844

7-AGE. 80 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Norfolk Va

PARENTS.

10-NAME OF FATHER Andrew Mosley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14-

(Informant) Mrs Herman Heinfelder

(Address) 4411 Liberty Heights Ave

AUG 1 1924

ROBERT R. KRAUTER, Registrar.

192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 8-1924

17-I HEREBY CERTIFY, That I attended deceased from ... 19.. to Aug 8 19 24

that I last saw h.. alive on Aug 8 19 24

and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed) M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19.. PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug 11 1924

UNDERTAKER. H. J. Tucker & Son

ADDRESS Northern

R. 8—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89353

CERTIFICATE OF DEATH. 122-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 S. Ellwood Ave. WARD)

2-FULL NAME Andrew Paszka

(a) RESIDENCE NO. 1222 S. Ellwood Ave. WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6- 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Paszka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Emelia Rutkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Son Peter Paszka 1222 S. Ellwood Ave

15 AUG 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 1926

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to August, 1924, that I last saw h~~i~~alive on August, 1924 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Chronic cirrhosis of liver (Alcoholic) 8 (duration) yrs. 8 mos. 1 month

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bruno L. Lamparski, M. D.

, 19 (Address) 243 E. Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Aug 12 1924

20 UNDERTAKER Stephen J. Krakowski ADDRESS 100 Stenson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89354 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89354

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Makowski

(a) Residence No. 232 Cambridge St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 1924 Robert P. Harrison, Registrar.

AUG 11 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-9-24

17- I HEREBY CERTIFY, That I attended deceased from 8-2, 1924, to 8-9, 1924, that I last saw h— alive on 8-9, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude A. Drake M. D.

8-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pennsylvania Cem. DATE OF BURIAL. Aug 12 1924

20-UNDERTAKER. Hopley & Mackowski ADDRESS 1008 S. Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 89355 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89355

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 9 E. Ostend St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Pauline Strube

(a) Residence No. 9 E. Ostend St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Mar.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Strube

6-DATE OF BIRTH (month, day and year) July 18 1851

7-AGE. 73 yrs. mos. 22 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS:

10-NAME OF FATHER. Henry Reinheimer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Henry Strube

(Address) 9 E. Ostend St

15- Filed AUG 11 1924 Albert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924 to Aug 10, 1924

that I last saw h... alive on Aug. 8, 1924

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Aortic sclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. E. Hawkins M. D

Aug. 12, 1924 (Address) 1 Randall St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery — DATE OF BURIAL. Aug. 12, 1924

20-UNDERTAKER. F. A. Krause & Son — ADDRESS 703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89356

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., ... WARD) 12

2-FULL NAME Charles Pfleger.

(a) RESIDENCE NO. 214 E. Preston St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married..

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tin plate
(b) General nature of industry, business, or establishment in which employed (or employer) decorator.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buffalo, N.Y.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Nettie Ethridge. (Address) 214 E. Preston St.

15 Filed AUG 11 1924, 192.. Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Unquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Aug. 9, 1924. (Address) 101 W. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 214 E. Preston Street.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 11 1924

20 UNDERTAKER John P. Denny — ADDRESS 715 Light

INFORMATION REQUIRED, WHERE NOT KNOWN, SHALL BE SUPPLIED. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89357 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89357

CERTIFICATE OF DEATH. X 127

1-PLACE OF DEATH Church Home and Infirmary. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Archer.

(a) RESIDENCE NO. Blair, Md. ST., WARD Blair Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Blair (State or country) Md

PARENTS

10 NAME OF FATHER Henry H Archer

11 BIRTHPLACE OF FATHER (city or town) Harford (State or country) Co Md

12 MAIDEN NAME OF MOTHER Mary E Wallas

13 BIRTHPLACE OF MOTHER (city or town) Kent Co Md (State or country)

14 Informant Mrs Graham Archer (Address) Blair Md

15 AUG 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to August 10, 1924, that I last saw him alive on August 10, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pancreatitis, Chronic

Cholangitis, Chronic

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Blair. Md.

Did an operation precede death? Yes Date of Aug 9. 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation Autopsy

(Signed) Gaetano Panetteri, M. D.

Aug 11 1924 2 March Home Rd Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fellowmount Cemetery	August 12, 24
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son Co	Orchard & McCollough

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Wm L. Weber

D 89358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

D 89358

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

2-FULL NAME Wm Weber.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2101 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 6 1875

7-AGE 49 yrs. 1 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hardware

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Peter Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Lutheran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. Wm Weber.

(Address) 2101 W. Lexington

15- Filed AUG 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10 24.

17- I HEREBY CERTIFY, That I attended deceased from 7-30 1924 to 8-10- 1924

that I last saw him alive on 8-10 1924

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis following ruptured appendix

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/30/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Emil Novak, M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Aug 13 1924
20-UNDERTAKER.	ADDRESS
Harry N Clunaca	4704 Redgewood Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89359

CERTIFICATE OF DEATH.

160

D 89359

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital ST. WARD)

2-FULL NAME Inf Roland Tarr

(a) RESIDENCE NO. 4207 Walnut Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1, 1924.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. Gen'l Hospital
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Tarr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Centerville Md.

12 MAIDEN NAME OF MOTHER Vera McDowell

13 BIRTHPLACE OF MOTHER (city or town) Lawyer
(State or country) Penn

14 Informant Vera Tarr mother
(Address) 4207 Walnut Ave

15 Filed AUG 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Aug 10, 1924, that I last saw him alive on Aug 10, 1924, and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno A Leuchtenberg, M. D.

, 19 (Address) 1110 Jenkins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Aug 12 1924

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2173 Pa Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89360

CERTIFICATE OF DEATH.

31

D 89360

Registered No.....

1-PLACE OF DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Asylum Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Shedrick

(a) Residence No. 514 ~~East~~ West Preston St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of Thos. F. Shedrick

6-DATE OF BIRTH (month, day and year) 1890 Jan 3

7-AGE, 34 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer)..... At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland.

PARENTS:

10-NAME OF FATHER, Charles Cotaner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Esther Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address) Bay View Hospital

AUG 11 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/8/24

17- I HEREBY CERTIFY, That I attended deceased from 8-2- 19 24 to 8/8 19 24 that I last saw h~~e~~er alive on 8/8 19 24 and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Pyopneumothorax + Lung abscess, following an unresolved Pneumonia Left Side (Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Operative Shock (Duration) yrs. mos. 2 hrs.

18-Where was disease contracted if not at place of death? 514 ~~East~~ West Preston St.

Did an operation precede death? Yes Date of 8/8/24.

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory tests - Operative findings

(Signed) Jno. P. C. Thompe M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
N.W. Cubary Cemetery	Aug 12 19 24
20-UNDERTAKER,	ADDRESS
Jos. M. Johnson	317 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a LEGAL DOCUMENT and should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

89361

173,162 med

HEALTH DEPARTMENT—CITY OF BALTIMORE

JOHNS HOPKINS ~~HOSPITAL~~

CERTIFICATE OF DEATH.

D 89361

X 129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Carter

(a) RESIDENCE No. 513 Pamah & T ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 26 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 641

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER John Gaskins

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Va

12 MAIDEN NAME OF MOTHER Susan Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Robert B. Harrison, Registrar

AUG 1 1924

Dental Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1924

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1924, to July 31, 1924

that I last saw h alive on July 31, 1924

and that death occurred, on the date stated above, at 10-2 P.m.

The CAUSE OF DEATH* was as follows:

Hypertension, Chronic nephritis,

Myocardial insufficiency

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Septicemia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hannon, M. D.

8/1, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89362

CERTIFICATE OF DEATH.

84

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

2-FULL NAME James Banks

(a) RESIDENCE NO. 245 Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/17/63

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		16		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work non

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy Banks (Address) 245 Pearl St

15 Filed AUG 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-8, 1924, to 8-10, 1924, that I last saw him alive on 8-10, 1924, and that death occurred, on the date stated above, at 445 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insuffiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tetany

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical evidence

(Signed) Geo B. Sybert, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 8/10/24

UNDERTAKER R C Gross

ADDRESS 1406 W Lexington

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89363

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2420 Mc Elderry St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Jarousek

(a) Residence No. 2420 Mc Elderry St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of John Jarousek

6-DATE OF BIRTH (month, day and year) unknown

7-AGE 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jacob Ciska

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

11-(Informant) Paul Stones

(Address) 2420 Mc Elderry St

15-Filed ..... Robert P. Harrison, Registrar.

G 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 9/24

17- I HEREBY CERTIFY, That I attended deceased from May 1 19 24 to Aug. 9 19 24

that I last saw h-r alive on Aug. 9 19 24

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) pulmonary edema

(Duration) 0 yrs. 0 mos. 3 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward Dorsch M. D

19 (Address) 26 E Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL, Aug 12 1924

20-UNDERTAKER Paul Cracoby — ADDRESS 1906 Aisquith

WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89364

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hosp ST., ... WARD)

2-FULL NAME Lewis Steinberger

(a) RESIDENCE NO. 544½ N. Gay ST., ... WARD 1

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 666

9 BIRTHPLACE (city or town) (State or country) Frederick, Md

PARENTS

10 NAME OF FATHER Marcus Steinberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Estelle Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lewis Steinberger (Address) 544 N. Gay St.

15 Filed AUG 11 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/24

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to Aug 9, 1924, that I last saw him alive on Aug 9, 1924, and that death occurred, on the date stated above, at 5 50 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & hypertension

Mitral regurgitation & cardiac hypertrophy. Chronic interstitial nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Thompkins M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Aug 11 1924
20 UNDERTAKER J. Ahrens & Co	ADDRESS 1611 Mad Ave

Burial Permit Clerk's

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89365

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 E. Madison St., Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Cummings

(a) Residence No. 1012 E. Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) — 1870

7-AGE, 54 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Simon Cummings

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER Amanda Gale

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Charles Cummings

(Address) 1012 E. Madison St.

15- Filed AUG 11 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 9 24

17- I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to Aug 9, 1924, that I last saw h[illegible] alive on Aug 9, 1924, and that death occurred, on the date stated above, at 1.00 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frank E. Waymouth, M. D.

(Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, Aug 12 24

20-UNDERTAKER Chas. H. Jenson ADDRESS 486 N. Carroll

SH

WHILE PENALTY, WITH SUMMONS, may be imposed for failure to report DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89366 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89366

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 6337 N. Carrollton Ave Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Scalley

(a) Residence No. 6337 N. Carrollton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Agnes Scalley

6-DATE OF BIRTH (month, day and year) March 17 1924

7-AGE 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Scalley

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Ireland

14- (Informant) Mary Agnes Scalley
(Address) 6337 N. Carrollton Ave

15- Filed ..... Robert P. Harrison, Registrar.

AUG 11 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924 to Aug 10 1924

That I last saw h. alive on Aug. 10 1924,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy M. D.

Aug 11 1924 (Address) 2801 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL.

St. Mary's Evans Aug. 13, 1924

20-UNDERTAKER — ADDRESS

John O. Mitchell 1201 W. Fayette St.

WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89367

CERTIFICATE OF DEATH. X49

D 89367

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Charles B. Judd (or W.)

(a) RESIDENCE NO. Roseville ST., WARD Roseville, N. J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Mr Charles B Judd

6 DATE OF BIRTH (month, day, and year) April 25, 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Thomas Windsor

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Cordelia Stokem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant C. E. Rice
(Address) 4504 Springdale Ave

15 AUG 11 1924 . 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1924, to Aug 10, 1924, that I last saw h.e alive on Aug 10, 1924 and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder with Metastasis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cystitis + pyelitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Roseville. N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Raymond T. Johnston, M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sound Brook N.J.	Aug 13 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89368

CERTIFICATE OF DEATH.

75-001

1-PLACE OF DEATH Siding Sanatorium Norwood Hgts REGISTERED NO.....

CITY OF BALTIMORE: (No. near Catonsville, Md ST.: 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Emma Crow

(a) RESIDENCE. No. 1312 Mulberry ST.. WARD (If not resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign born? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fayetteville (State or country) N.C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Miss Rosa a Wallach
(Address) 1312 W Mulberry St

Filed AUG 11 1924, 19.. Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to August 9 1924, that I last saw her alive on August 9, 1924, and that death occurred, on the date stated above, at 11-8, m.

The CAUSE OF DEATH* was as follows:

Cardio Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia & Unumbed Left Lecture (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. W. Linton Cliff, M. D.

8/10, 1924 (Address) 1312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fayetteville N. C.	Aug 14 1924
20 UNDERTAKER John J Mitchell	ADDRESS 1201 W Fayette St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item for-mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

French J

D 89369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89369

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1306 Hollins St – St.,..... Ward) 0

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. French

(a) Residence No. 1306 Hollins St – St.,..... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Howard French

6-DATE OF BIRTH (month, day and year) May 2 1893

7-AGE. 31 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS:

10-NAME OF FATHER, Rudolph Finnigh

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Barringer

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country),

14-Informant Howard French

(Address) 1306 Hollins St –

15-Filed AUG 11 1924 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 9 1924

17- I HEREBY CERTIFY, That I attended deceased from 8/20/23 19.... to 8/9/24 19 24

that I last saw h.r alive on 8/9/24 19.....

and that death occurred, on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Adenocarcinoma of Uterus

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? –

Did an operation precede death? Yes Date of Aug 1923

Was there an autopsy? No

What test confirmed diagnosis? Gross pathological

(Signed) F W Bunts M. D

8/11/24 19 (Address) 1306 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Patterson | DATE OF BURIAL, Aug 12, 1924

20-UNDERTAKER, Wm Cook | ADDRESS 512 E. Lex

Burial Permit Clerk

INSTRUCTIONS—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 89370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

231

D 89370

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Belt ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine E. Walton

(Residence in Baltimore: No. 1811 Belt St.; ..... yrs., ... mos. ..... ds.)

N

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 5th, 1923 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel Walton

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Nettie Scheckels

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Daniel Walton

(Address) 1811 Belt St.

15- Aug 11 1924

Robert P. Harrison, 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 3rd, 1924, to August 10th, 1924, that I saw her alive on August 9th, 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculor meningitis

(Duration) ... yrs. ... mos. 8 ds.

(Signed) Harry Kleibel M. D.

8/11, 1924 (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Nat. Oliver — DATE OF BURIAL, Aug. 12, 1924

20-UNDERTAKER Margaret D. Flynn — ADDRESS 1422 Light St.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89371

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 827 East Chase St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Alice Burke

(a) Residence No... 827 East Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Burke

6-DATE OF BIRTH (month, day and year) Jan. 14th. 1879

7-AGE.	If LESS than 1 day,
45 yrs. 6 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, John Monaghan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Jane Lansdale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14-(Informant) Edward J. Burke

(Address) 827 E. Chase St.

15-Filed: AUG 11 1924

Robert P.J. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 11-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1923 to Aug 11 1924

that I last saw h[illegible] alive on August 10 1924

and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Secondary Carcinoma of the Spine of 6th Cervical, 7th & 12th Dorsal & 5th Lumbar Vertebrae

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Right Breast

(Duration) 1 yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination & X Ray

(Signed) Wm R Geraghty M. D

8/11, 1924 (Address) 2038 Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	8/14/24

20-UNDERTAKER.	ADDRESS
C.F.Evans & Son-	118 W. Mt Royal Ave.

8—WRITE PLAINLY, with pen and ink and avoid the use of abbreviations. All items must be answered or the word "unknown" or the proper word "none" should be written EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89372

CERTIFICATE OF DEATH.

7H-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Steamer Talbot, Chesapeake Bay. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Brady. (C).

(a) RESIDENCE NO. 720 Grindall Court. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) January 15, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	24.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fireman on
(b) General nature of industry, business, or establishment in which employed (or employer): Steamer Talbot.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Maggie Mitchell. (C). (Address) 720 Grindall Coutt.

15 Filed AUG 11 1924, 192.. Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Aug, 9th, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 11 1924
20 UNDERTAKER	ADDRESS
Jno. E. Hoofs	401 Cor. Conway St.

Should be stated EXACTLY. PHYSICIAN should make mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89373 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89373

CERTIFICATE OF DEATH. 113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 716 N Collington Ave ST., WARD)

2-FULL NAME Paul Holzknecht.

(a) RESIDENCE No. 716 N Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wh 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17. 23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Holzknecht

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Annie Mallal

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Peter Holzknecht (Address) 716 Collington Ave

15 Filed AUG 11 1924, 19.....

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 19 24

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 19 24, to Aug 10 19 24

that I last saw h[illegible] alive on Aug 10 19 24

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Mes Colitis.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Atrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Revayek, M. D.

19 (Address) 1801 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 12 1924

20 UNDERTAKER Frank Crockett Son — ADDRESS 1906 E Monument

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. Bessie Pawlowska

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89374 ✓ D 89374

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Greene & Lombard ST.) WARD)

2-FULL NAME Bessie Pawlowska

(a) RESIDENCE NO. 237 S. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignatius Pawlowski

6 DATE OF BIRTH (month, day, and year) May 21 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Casimier . Nowak

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Ida. Kozak

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr Ignatius. Pawlowski

(Address) 237 S. Chapel Street

15 Filed ....., 19 Robert P. Harrison, Registrar

AUG 11 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 . 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 , 1924 , to Aug 11 , 1924 ,

that I last saw h.. alive on Aug 11 , 1924 ,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic congestion of lungs. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of Aug 8.

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) M Edwards. M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug. 14 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89375 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89375

CERTIFICATE OF DEATH. 113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 S. Ann St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Romanowski

(a) Residence No. 229 S. Ann St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 15 1924

7-AGE. ....yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Romanowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Veronica Peplowska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Mr. Frank Romanowski

(Address) 229 S. Ann Street

15- Filed AUG 11 1924 19?? Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 19 24 to Aug 9th 19 24

that I last saw her alive on 19 , and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Erdem M. D

8/11 1924 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cem.	Aug 11 1924
20-UNDERTAKER,	ADDRESS
John M Weber	1803 Bank St

WHITE—PENCIL WRITING MUST NOT SHOW. Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

D 89376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89376

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 N. Pulaski ST., WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma G. Kaufmann

(a) RESIDENCE No. 1809 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jersey City
(State or country) N. J.

PARENTS

10 NAME OF FATHER Henry P. Kaufmann

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret E. Reip

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Margaret E. McAllister
(Address) 1809 N. Pulaski St.

15 Filed AUG 11 1924, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1923, to Aug 11, 1924, that I last saw h[illegible] alive on Aug 11, 1924, and that death occurred, on the date stated above, at 1 50 A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Mylitis,

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Symptoms

(Signed) Abraham Schapiro, M. D.

, 19 (Address) 2029 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Aug 13, 19 24

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1844 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on informant should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89377

CERTIFICATE OF DEATH. X 31

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1517 N. Dallas ST., (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wright

(a) RESIDENCE NO. Lakes Ville, N. C. ST., WARD Lakesville N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female col,

4 COLOR OR RACE:

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE — Years: 19 — Months: — — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lakesville N. C.

PARENTS

10 NAME OF FATHER Russell Price

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER Catherine Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant Catherine Price

(Address) Lakesville N. C.

15 AUG 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to Aug. 9, 1924, that I last saw he alive on Aug. 5, 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Rheumatic fever

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

(Address) 1520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakeville N. C. DATE OF BURIAL: Aug 12 24

20 UNDERTAKER: Mrs R. A. Elliott ADDRESS: 1725 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89378 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89378

CERTIFICATE OF DEATH. 7/4-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 Ashburton ST., WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Wolfe

(a) RESIDENCE No. 1211 Ashburton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Wolfe

6 DATE OF BIRTH (month, day, and year) Feb. 28 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Arnold Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sarah Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs Annie Wolfe
(Address) 1211 Ashburton St

15 Filed AUG 11 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennebery, M. D. (Coroner.)

Aug 11, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath. Cem	Aug 13 1924
20 UNDERTAKER Robert S. Little	ADDRESS 2502 Edmondson Ave

AUG 11 1924

WHITE CERTIFICATE, WHITE ENVELOPE. THIS CERTIFICATE MUST BE FILLED OUT IN INK OR TYPEWRITTEN. PHYSICIAN'S RECORD. DATE OF DEATH should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89379

CERTIFICATE OF DEATH.

129 D 89379

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2514 Frederick Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Rev. Romoser

(a) Residence No. 2514 Frederick Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? ——yrs. ——mos. ——dy.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. H. C. Romoser

6-DATE OF BIRTH (month, day and year) Nov 27th 1849

7-AGE, 74 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (City or town) Ballo. (State or Country) Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (City or town) Ballo. (State or Country) Md.

12-MAIDEN NAME OF MOTHER, L. Keller

13-BIRTHPLACE OF MOTHER (City or town) Ballo (State or Country) Md.

14- (Informant) Louis H. Romoser

Address 2514 Frederick Ave

AUG 12 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

W. A. Cof

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 11/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Aug 11 1924

that I last saw her alive on Aug 11 1924

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Walter A Cof M. D.

Aug, 1924 (Address) 54 S Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park. DATE OF BURIAL, Aug 13th 1924

20-UNDERTAKER, H.B. Kappert ADDRESS 1850 N Ballo St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89380

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH Bayview Hospital

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Williams

(a) Residence No. 1054 Aggle Ave St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Blk

5-~~Single, Married, Widowed, or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1890

7-AGE, 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do

12-MAIDEN NAME OF MOTHER, do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), do

14- (Informant) Bay View Hospital

(Address)

15- Filed AUG 1 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 24 19 24 to Aug 10, 19 24

that I last saw h.e alive on Aug 10, 19 24

and that death occurred, on the date stated above, at 10 15a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Chronic)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypochrosis with Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical + Autopsy findings

(Signed) H. F. Edwards M. D.

8/10 19 24 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pocomoke City, Md. DATE OF BURIAL, 8/15 19 24

20-UNDERTAKER, John H. Trader ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89381

CERTIFICATE OF DEATH.

1735 D 89381 113

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Healy

(a) RESIDENCE NO. 947 Collington Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

White

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 20-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	—	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Marie ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records Johns Hopkins Hospital (Address)

15 Filed AUG 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Aug 10, 1924

that I last saw him alive on Aug 10 - 1924

and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt. Washington

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Beech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 12 1924

20 UNDERTAKER Wm. C. Miller — ADDRESS 2334 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89382

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 242 S. Eastle St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schwarzmann

(a) Residence No. 242 S. Eastle St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Anna Schwarzmann

6-DATE OF BIRTH (month, day and year) June 24th 1860

7-AGE. 64 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. City Employee

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. George Schwarzmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Dont Know.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant). Benj. F. Schwarzmann

(Address) 2017 E. Lombard St.

15-Filed AUG 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) aug. 10th 1924

17-I HEREBY CERTIFY, That I attended deceased from aug 9 19 24 to aug 10 19 24

that I last saw him alive on aug 10 19 24

and that death occurred, on the date stated above, at 9 45 P. M.

The CAUSE OF DEATH* was as follows: Intestinal Toxic Chn Probably due to Grippe (Pneumonia ?)

(Duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) a cute Cardiac Dilatation

(Duration) yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. Fred Thurnau M. D.

8-11, 1924 (Address) 800 N. Gath Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem

DATE OF BURIAL. aug 14 1924

20-UNDERTAKER. Lilly & Geiler

ADDRESS 4038 W. Wash St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 89383

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 W. Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Reid

(a) Residence No. 1101 W. Lanvale St., 16 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? 68 yrs. 2 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Saml. M. Reid

6-DATE OF BIRTH (month, day and year) May-12-1856

7-AGE, 68 yrs. 2 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER Jos. Reinhart

11-BIRTHPLACE OF FATHER (city or town) (State or Country). unknown Germany

12-MAIDEN NAME OF MOTHER Elizabeth Eddleman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

14-(Informant) Saml. M. Reid (Husband)

(Address) 1101 W. Lanvale St

AUG 1 2 1924, 19..

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug-9-1924

17- I HEREBY CERTIFY, That I attended deceased from May 31st, 1924, to Aug 9, 1924, that I last saw h.. alive on Aug 9, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Degeneration

(Duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senile Bronchopneumonia

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Charles Gatch, M. D.

Aug 9th, 1924 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, Aug 13, 1924.

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

EXACTLY. PHYSICIANS sh... should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89384

CERTIFICATE OF DEATH.

90

D 89384

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac McNeary

(a) Residence No. 302 Worsely St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Kentucky

PARENTS

10-NAME OF FATHER, Amos McNeary

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address).....

15- AUG 12 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-10-24

17- I HEREBY CERTIFY, That I attended deceased from 7-30, 1924 to 8-10, 1924

that I last saw h~~e~~ alive on 8-10, 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension, Chronic Myocarditis;

Myocardial degeneration

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Grace M. D.

8-10, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
National Cemetery	Aug 12 1924
20-UNDERTAKER	ADDRESS
Joseph F. Rochester	1913 Jefferson St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89385

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH Ford Lane & Park Heights Ave Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

2-FULL NAME Julius Schloss

(a) Residence No. Ford Lane & Park Heights Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Schloss

6-DATE OF BIRTH (month, day and year) April 8/1864

7-AGE, 60 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wholesale
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Mnfg.
(c) Name of employer .....

9-BIRTHPLACE (city or town), (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Moses Schloss

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Jetta Heidelberger

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Germany

14-(Informant) Michael Schloss

(Address) Carroll Rd

15-AUG 2 1924 ROBERT F. KRAFFERT, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 10th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1924 to Aug 10, 1924

that I last saw h[illegible] alive on Aug 10, 1924

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris —

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia *

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Balt. Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab. Test

(Signed) Joseph William Kelly, M. D.

, 19 (Address) 940 Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Balto Hebrew — DATE OF BURIAL, Aug 12th, 1924

20-UNDERTAKER, Ward Goodheim — ADDRESS 1118 N Howard St

---

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89386

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., WARD)

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lyda Edwards

(a) RESIDENCE NO. 2048 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Edwards

6 DATE OF BIRTH (month, day, and year) July 28/91

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	33		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Bunley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Matilda Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Johns Hopkins Hospital

15 Filed AUG 12 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1924, to Aug 10, 1924, that I last saw her alive on Aug 10, 1924, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Intra uterine Haemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature separation of Placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 10.

Was there an autopsy? yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Eden M. D.

8/13, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL 8/13 1924

20 UNDERTAKER Philip Henrig ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89387

CERTIFICATE OF DEATH. 188-003 D 89387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton Veid

(a) RESIDENCE NO 2118 Jefferson St
(Usual place of abode) ST., WARD

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Ida Veid

6 DATE OF BIRTH (month, day, and year): Nov 25/1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Gardner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Ida Veid
(Address): 2118 Jefferson

15 Filed [illegible], 192 Robert F. Barker
Burial Permit (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture at Base of Skull
(Struck by automobile, inquest Aug 11/24)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)

8/10/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 12 24
20 UNDERTAKER: John Reehil	ADDRESS: 2008 Aliceanna

AUG 12 1924

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89388

CERTIFICATE OF DEATH.

7/4-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1602 E. Preston St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Margaret B. Clemens

(a) Residence No. 1602 E. Preston St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm B Clemens

6-DATE OF BIRTH (month, day and year) Jan 8. 1855

7-AGE. 69 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or....mln.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Krieger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mrs F. Rieders
(Address) 1602 E Preston

15-Filed AUG 12 1924 Robert P. Garrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10. 24

17-I HEREBY CERTIFY, That I attended deceased from July 25 19 24 to Aug 10 19 24
that I last saw h.e alive on Aug 10 19 24
and that death occurred, on the date stated above, at 9.15a m.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Richardson M.D.
(Address) 1320 E. 20 St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Olivet Cem — DATE OF BURIAL, Aug 12 1924

20-UNDERTAKER. John Ulrich — ADDRESS 2105 Ellam

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Curtis)

D 89389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89389

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor. Calhoun & Fremont Ave. ST., ... WARD)

2-FULL NAME Wm. H. Curtis

(a) RESIDENCE No. 1566 Fremont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. Curtis

6 DATE OF BIRTH (month, day, and year) about 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal & Ice dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Eliz. Curtis
(Address) 1566 Fremont Ave

15 Filed AUG 21 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Aug 8, 1924 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 18 1924

20 UNDERTAKER Virgie T. Brooks — ADDRESS 1463 N. Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89390

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 20 Md. Gen. Hosp. ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence A. Webb

(a) RESIDENCE NO. 206 W. Biddle St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colrd	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. T. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Gray
(Address) 206 W. Biddle St.

15 Filed AUG 12 1924, 192.... Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above. (autopsy)

The CAUSE OF DEATH* was as follows: 2.7.H

Acute suppurative Mastoiditis

(duration) ..... yrs. ..... mos. 2 wks ds.

CONTRIBUTORY (Secondary) Septic pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, (Coroner.), M. D.

Aug. 12, 1924 (Address) 2 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 12 1924
20 UNDERTAKER	ADDRESS
Mrs R. C. Elliott	1725 Division

AUG 12 1924

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21-E.B.R.S.—400 Bks.

D 89391 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89391

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 132 Dolphin St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gayett

(a) Residence No. 132 Dolphin St., ... Ward 11
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. C

5-Single, Married, Widowed, Divorced, (Write the word.) Widow.

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Dont Know

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown.

14- (Informant) Mrs. R. G. Ellett

(Address) 1725 Ashland Ave.

15- Filed AUG 1 2 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). August 9-24

17- I HEREBY CERTIFY, That I attended deceased from December 10 1923 to August 9 1924 that I last saw her alive on August 8 - 1924 and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Complication Disease (Duration) 3 yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. W. Kennard M. D

8-9 1924 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery DATE OF BURIAL. Aug 12, 1924

20-UNDERTAKER. Mrs. R. G. Ellett ADDRESS 1725 Ashland Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Helen Lukenczuk

D 89392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89392

CERTIFICATE OF DEATH.

113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 10th St Morrell Park St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elena Lukenczuk

(a) Residence No. 10th Morrell Park St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of X

6-DATE OF BIRTH (month, day and year) 4-26-24

7-AGE, ...yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Morrell Park (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Lukenczuk

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Mary Konfus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) John Lukenczuk

(Address) 10th St Morrell Park

15- Filed AUG 12 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/10/24

17- I HEREBY CERTIFY, That I attended deceased from 8-6-1924 to 8-11-1924 that I last saw her alive on 8-11-1924 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency.

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. Hall M. D

8-12, 1924 (Address) Halethorp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL, August 12 1924

20-UNDERTAKER, John M Weber — ADDRESS 1803 Bank St

WHERE PERMIT WITHHELD, GIVE NAME OF INFORMANT AND REASON. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89393

CERTIFICATE OF DEATH. 161-09

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1158 Low St ST., WARD)

2-FULL NAME Baby Allen

(a) RESIDENCE NO 1158 Low St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug 10 / 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8 hrs.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country) (1158 Low St)

PARENTS

10 NAME OF FATHER Charlie Flood

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Forest Depot Va

12 MAIDEN NAME OF MOTHER Alene Allen

13 BIRTHPLACE OF MOTHER (city or town) Forest Depot Va
(State or country) 1158 Low St (3 wks)

14 Informant ~~Alene Allen~~ Lilla Common
(Address) 1158 Robert St Baltimore,

15 Filed AUG 12 1924 Burial Permit 1677 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Immature - Premature

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Allen, M. D.
(Coroner.)
8-11, 192 4 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	AUG 11 1924

20 UNDERTAKER ..... ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89394

CERTIFICATE OF DEATH.

129

D 89394

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nora Bachmann

(a) RESIDENCE NO 329 Scott ST., WARD 21

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Wm F Bachmann

6 DATE OF BIRTH (month, day, and year) Sept 12 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Geo Barthrop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Thrust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm F Bachmann
(Address) 329 Scott St

15 Filed AUG 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy,~~ or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~inquiry or inquiry.~~) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia a few hours

(duration) yrs. mos. ds.

(Signed) W K Lowenthal, M. D.
(Coroner.)

8-11-1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Aug 14 1924
20 UNDERTAKER Wm Fields	ADDRESS 120 W Lombard

BEFORE ANSWERING BE CAREFUL: PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89395

D 89395

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Tate

(a) RESIDENCE No ~~Colgate~~ Md. 513 N. Madeira St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) March 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Tate

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie Basohues

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Johns Hopkins Hospital
(Address)

15 Filed AUG 21 1924 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro_intestinal Indigestion

Malnutrition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J H Cole, M. D.
(Coroner.)

8/13/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Aug 13 1924
20 UNDERTAKER	ADDRESS
Kendall & Deppe & Son	37 Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89396

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wise

(a) RESIDENCE NO. 1636 Millinan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/30/24

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ellis Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Md~~ Va

12 MAIDEN NAME OF MOTHER Ethel Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant (Address) Johns Hopkins Hospital.

6/2 1924 1682 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 2, 1924, that I last saw him alive on Aug 2, 1924, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Bullmer M. D.

8/3, 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 8/3 1924

20 UNDERTAKER — ADDRESS

Commissioner Hea...

JOHNS HOPKINS HOSPITAL AUG 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89397

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby Hawkins

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/3/24

7 AGE — Years — Months — Days: 4 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Kelleher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant (Address) Johns Hopkins Hospital.

15 Filed AUG 2 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/3, 1924 to 8/9, 1924, that I last saw him alive on 8/7, 1924 and that death occurred, on the date stated above, at 3 00 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan M. D.

8/7, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: AUG 12, 1924

20 UNDERTAKER .....

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... UPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89398

CERTIFICATE OF DEATH.

101-001

D 89398

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 W Preston ST., WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hedwig Sartt

(a) RESIDENCE No. 109 W Preston ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Color	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Sartt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer) Midwife

(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER Nicholas Brown

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Samuel Sartt. (Address) 109 Preston St.

15 G 1 2 1924 Robert P. Harrison, A. M. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7th, 1924, to Aug. 10th, 1924, that I last saw h.. alive on Aug. 9th, 1924, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) 1 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Ellis M. D.

, 19 (Address) 92 W Mad.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug. 13th 1924

20 UNDERTAKER Jas. M. Johnson

ADDRESS 1309 Druid Hill Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Bks.

D 89399 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89399

CERTIFICATE OF DEATH. 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD)

2-FULL NAME John Young

(a) RESIDENCE NO. 2466 David Hill Ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Katherine Youngs

6 DATE OF BIRTH (month, day, and year) July 16th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher & Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 012

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER John B. Youngs

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Amelia E. Bird
(Address) 2466 David Hill ave.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

AUG 12 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Aug 11, 1924, that I last saw him alive on Aug 11, 1924, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency, chronic parenchymatous nephritis

undetermined (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Clewell Howell, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Ridge Cemetery	Aug. 13th 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Shriver	918 Edmondson ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and child state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89400 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39400

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 55 Forest Ave. Hillsdale St., ... Ward) Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... George M. Basford

(a) Residence No. 55 Forest Ave. Hillsdale St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Basford

6-DATE OF BIRTH (month, day and year) Sept. 29 1858

7-AGE. 65 yrs. 10 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Woodberry Mills

9-BIRTHPLACE (city or town) (State or Country): Frederick Co. Md.

PARENTS.

10-NAME OF FATHER: Alfred Basford

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick Co. Md.

12-MAIDEN NAME OF MOTHER: Delina Stallings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14- (Informant): Mrs. Mary J. Basford

(Address): Hillsdale Md.

15- Filed AUG 12 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August, 12th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 12, 1924, that I last saw him alive on Aug 12, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis — Chronic Parenchymatous Nephritis —

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. 12 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Neblett, M. D.

Aug 12, 1924 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine Cem	Aug 15, 1924
20-UNDERTAKER,	ADDRESS
Joseph B Cook	1003 W. Baltimore St

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH correctly, plainly and completely. Exact statement of OCCUPATION is very important. Blanks should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day, hours or minutes must be stated. Cause of death must be stated in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89401 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89401

CERTIFICATE OF DEATH. 14-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2214 Wilkens Avenue St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elexina Poole

(a) Residence No. 2214 Wilkens Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: FeMale

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James E.Poole

6-DATE OF BIRTH (month, day and year) June 18,1854

7-AGE: 70 yrs. 1 mos. 23 ds. If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Paul Fillenger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Mary Ellis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs.Mollie Kolb

(Address) 2214 Wilkens Avenue

15- Robert P. Harrison, Registrar.

AUG 21924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 10,1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 5, 19 24 to Aug 10, 19 24, that I last saw h.. alive on Aug 10, 19 24 and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Cerebral Hemorrhage (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

8-11-, 1924 (Address) 743 W. Fayette Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Aug 13, 1924
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Gilmor St

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every question should be carefully answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89402

CERTIFICATE OF DEATH. 7/4-001

D 89402

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4207 Groveland ave WEST ARLINGTON ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen A. Twichell

(a) RESIDENCE NO. 4207 Groveland ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carlos A. Twichell

6 DATE OF BIRTH (month, day, and year): April 4 1853

7 AGE — Years: 71 — Months: 4 — Days: 7 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Buffalo New York

PARENTS

10 NAME OF FATHER: Roswell G. Dewey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Verysburg New York

12 MAIDEN NAME OF MOTHER: Eliza J. Carpenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Java New York

14 Informant: Henry G. Twichell

(Address) 4207 Groveland ave

15 AUG 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 11, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1924 to Aug. 11, 1924

that I last saw her alive on Aug. 11, 1924

and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmett Lorell M. D.

, 19 (Address) 3705 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug 13 1924

20 UNDERTAKER: Chas. S. Black

ADDRESS: 742 W. North Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89403

CERTIFICATE OF DEATH.

197 D 89403

1-PLACE OF DEATH Pronounced dead at

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

CITY OF BALTIMORE: (No. St Josephs Hospital ST., WARD) 12

2-FULL NAME John Henry Parker

(a) RESIDENCE No 205 Spring St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Parker.

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Streetcar Op
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant St Josephs Hospt. (Address)

15 Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet Wound Chest Instantaneous Homicide

Was Policeman in this City (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. H. Feuling, M. D. (Coroner)

Aug 12 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Loudon Cemetery Aug 12 1924

20 UNDERTAKER — ADDRESS
J. Wm. R. G. Elliott 2[illegible] Madison

INSTRUCTIONS

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89404

CERTIFICATE OF DEATH. X 197

D 89404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Young

(a) RESIDENCE No. Furnes Station, Balto Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V. A.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Rudolph (Address) Furnes Station

15 Filed AUG 13 1924 ROBERT S. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound in abdomen Homicide

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pericolitis

(duration) yrs. mos. 3 ds.

(Signed) Jno. M. Houston M. D.

Aug 11, 1924. (Address) Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Furnes Station

Former or usual residence Furnes Station

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Aug 13 1924

20 UNDERTAKER: Mrs. R. C. Elliott — ADDRESS: Parkton Md

(Section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 188-003D 39405

D 89405

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L. Jefferson

(a) RESIDENCE NO. 2135 Division St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane E. Jefferson.

6 DATE OF BIRTH (month, day, and year) about 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bessie Adger (Address) 2135 Division St.

15 AUG 13 1924 ROBERT S. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) automobile accident.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

(Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Aug 13 1924

20 UNDERTAKER Mrs. R.G. Elliott ADDRESS 1525 Caroline

N.B.—WRITE PLAINLY, WITH UNFADING INK. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D 89406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Jackson

(a) RESIDENCE NO. 515 Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Basil Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mary Jackson 515 Pierce St.

15 Filed AUG 13 1924 ROBERT N. GRIFFITH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-9, 1924, to 8-10, 1924, that I last saw h[illegible] alive on 8-10, 1924, and that death occurred, on the date stated above, at 12:00 M

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 18

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologist

(Signed) [illegible], M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 13 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1925 Ashland Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.&R.S.—400 Blks.

D 89407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39407

CERTIFICATE OF DEATH.

44

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 Aisquith St., Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hauth

(a) Residence No. 916 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Widower or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Hauth

6-DATE OF BIRTH (month, day and year) April 17th 1860

7-AGE, 64 yrs. 3 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, John Hauth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Schneider

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) George Hauth

(Address) 2045 Eutaw ave

15- AUG 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to Aug 11, 1924, that I last saw him alive on Aug 10, 1924, and that death occurred, on the date stated above, at 3:30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General Inclusions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

8/11, 1924 (Signed) John Doetsch M.D.

(Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore County DATE OF BURIAL, August 13, 1924

20-UNDERTAKER, George Schulting & Sons ADDRESS 1126 E Monument St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 89408

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 810 N. Broadway St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Medora Gordon

(a) Residence No. 810 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr Charles Gordon

6-DATE OF BIRTH (month, day and year): Oct 24th 1855

7-AGE: 68 yrs. 9 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Leesburg Loudon Co Va

PARENTS.

10-NAME OF FATHER: Charles B. Bird

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Leesburg Loudon Co Va

12-MAIDEN NAME OF MOTHER: Mary E. Mullen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Alexandria Va

14-(Informant): Mr Ellen Bowen

(Address): 810 N. Broadway

15-Filed AUG 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 12, 24

17- I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h... alive on ....., 19....., and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): OK Dr Mullen

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Corner N. & E. Sts

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Hartman, M. D.

Aug. 12, 1924 (Address) 2314 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: August 14th 1924

20-UNDERTAKER: George A. Schilling & Sons — ADDRESS: 112 E. Monument St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89409

CERTIFICATE OF DEATH. X 113

D 89409

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3528 Esther Pl ST., WARD

2-FULL NAME Marshall Ellwood Shipley

(a) RESIDENCE No. 3528 Esther Pl ST., WARD Chicago Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. 4 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	1	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Chicago Ill
(State or country)

PARENTS

10 NAME OF FATHER Marshall Ellwood Shipley

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country)

12 MAIDEN NAME OF MOTHER Helen Frank

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania
(State or country)

14 Informant Marshall M Shipley
(Address) 3528 Esther Pl

15 Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) James H Ruben (Coroner), M. D.
Aug 11, 1924 (Address) 710 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loud Lawn Cemetery	Aug 13, 1924
20 UNDERTAKER John A. Inman 3000 E. Balto	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89410 — CERTIFICATE OF DEATH. X 31 — D 89410

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 135 North Highland ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Maxwell

(a) Residence No. 135 North Highland ave St., Ward. Tennessee

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 18, 1908

7-AGE. 16 yrs. 2 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Clearfield Tenn.

PARENTS.

10-NAME OF FATHER, J. W. Maxwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Clearfield Tenn

12-MAIDEN NAME OF MOTHER, Elvira Maxwell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ky.

14- (Informant) Mrs Elvira Maxwell

(Address) 135 North Highland ave

15- AUG 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 11, 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 3. 1924 to July 30 1924

that I last saw her alive on July 27 1924

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Acute Meningo Tuberculosis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Flu.

(Duration) — yrs. mos. ds.

18-Where was disease contracted if not at place of death? Tenn.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C. H. Rees M. D

, 19 (Address) 330 N Richards

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Catalpa Cem. — DATE OF BURIAL. Aug. 13, 1924

20-UNDERTAKER. John A. Mann — ADDRESS. E. Balto St.

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS. WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89411

CERTIFICATE OF DEATH. 31

D 89411

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Hall Alley ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Myrtle Hagner Lacer

(a) RESIDENCE. No. 1109 Hall Alley ST., 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a ~~married, widowed, or divorced~~ HUSBAND of ~~WIFE of~~ George C. Lacer

6 DATE OF BIRTH (month, day, and year) Feb 26, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. T. Hagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Esther Carter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Mother - Mrs. Esther Hagner (Address) 109 N. 1st St, Brooklyn, Md.

15 [illegible] 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924, to Aug 11, 1924, that I last saw her alive on Aug 10, 1924, and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	8-13 1924
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E Wash St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89412

CERTIFICATE OF DEATH. 74-001

D 89412

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 Robert St., ... Ward ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Redcross

(a) Residence No. 511 Robert St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Redcross

6-DATE OF BIRTH (month, day and year) Unknown 1870

7-AGE. 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chef

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Rebecca Redcross

(Address) 511 Robert St

Filed AUG 7 1924, 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924 to Aug 10, 1924, that I last saw him alive on Aug 8, 1924 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 1/2

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H S McCard M. D.

8/11, 1924 (Address) 2002 Division

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Auburn Cemetery	8/13, 1924
20-UNDERTAKER. John C. Woodside	ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89413

CERTIFICATE OF DEATH.

194 D 89413

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 680 Pin Alley ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Boulden

(a) RESIDENCE NO. 680 Pin Alley ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mamie Boulden

6 DATE OF BIRTH (month, day, and year) - - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Washer

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer Elite Laundry Co Balto Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Boulden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Stella Hall

(Address) 680 Pin Alley

15 Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924 to Aug 10, 1924. that I last saw him alive on Aug 10, 1924. and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Prostratio Thermica

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Howell M. D.

8/13/1924 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 13, 24
20 UNDERTAKER Samuel T Hensley	ADDRESS W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

89414 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89414

1-PLACE OF DEATH Municipal Tb Hospitals 31 Registered No.

City of BALTIMORE: (No. Bay view St., Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Peacock

(a) Residence No. 20 N. 11th St. Highland Town St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Sing.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 8th 1905

7-AGE. 20 yrs. 10 mos. 7 ds. If LESS than 1 day, hrs. or mins.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas. Peacock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Reeder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Hospital Records

(Address)

Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 10 24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1924 to Aug 10, 1924, that I last saw him alive on Aug 10, 1924, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Advanced Pulm TB

Myocardial Insufficiency ?

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinically autopsy

(Signed) J. D. Steele, M. D.

, 19 (Address) M. T. H. Bay View.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Carmel	Aug 13, 1924
20-UNDERTAKER,	ADDRESS,
John F Denny	715 Light st

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89415

CERTIFICATE OF DEATH.

45 D 89415

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2721 Tivoly Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm B. Wilkinson

(a) Residence No. 2721 Tivoly Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Esther Wilkinson

6-DATE OF BIRTH (month, day and year) Nov 17 1871

7-AGE, 53 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) St Marys Co (State or Country), Md

PARENTS.

10-NAME OF FATHER John O Wilkinson

11-BIRTHPLACE OF FATHER (city or town) St Marys Co (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E Adams

13-BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or Country), Md

14- (Informant) Esther Wilkinson

(Address) 2721 Tivoly Ave

15- Filed AUG 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 12-1924

17- I HEREBY CERTIFY, That I attended deceased from July, 1923, to Aug 12, 1924, that I last saw h. alive on Aug 12, 1924, and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 1923

Was there an autopsy? No Clin

What test confirmed diagnosis? .....

(Signed) H. L. Kruger M. D.

8/12, 1924 (Address) 2700 E Monument Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Millstone Md	Aug 13, 1924
20-UNDERTAKER.	ADDRESS
Robt J Jones Sec	St Marys

WRITE PLAINLY, WITH UNFADING INK. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39416

89416

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1360 N. Carey ST.; WARD)

2-FULL NAME Norman Benjamin Dyson.

(a) RESIDENCE. No. 1360 N. Carey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): June 22, 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): 1360 N. Carey

PARENTS

10 NAME OF FATHER: James Walter Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Corrie Edna Mosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Corrie Edna Dyson

(Address): 1360 N. Carey

Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924 to Aug 12, 1924; that I last saw him alive on Aug. 10, 1924; and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis.

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Artificial Feeding. Age-Heat (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

(Address) 1309 Portsman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	Aug 13 1924
20 UNDERTAKER	ADDRESS
Samuel Bond & Sons	1360 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89417

CERTIFICATE OF DEATH. 101-001

D 89417

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Wilson ST.; WARD)

2-FULL NAME Martha Bailey

(a) RESIDENCE. No. 552 Wilson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col-	Widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Dec 12th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer at home—

9 BIRTHPLACE (city or town) (State or country) Acmar. Va.

PARENTS

10 NAME OF FATHER William upton

11 BIRTHPLACE OF FATHER (city or town) Acmar Va (State or country)

12 MAIDEN NAME OF MOTHER Fanny upton

13 BIRTHPLACE OF MOTHER (city or town) Acmar Va. (State or country)

14 Informant Mrs Maggie Freeman (Address) 552 Wilson Street

15 Filed AUG 13 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11— 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th —, 1924, to Aug 11—, 1924

that I last saw her alive on Aug 11—, 1924

and that death occurred, on the date stated above, at 4 P— m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastro Intestinal Infection about (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Samuel A Bain, M. D.

, 19 (Address) 987 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Aug 13 1924

20 UNDERTAKER: Charles H Alexander

ADDRESS 1406 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89418

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S. Bentalou ST.; WARD) N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur W. Trabert

(a) RESIDENCE. NO. 613 S. Bentalou ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Trabert

6 DATE OF BIRTH (month, day, and year) Oct 13-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Salt. 166

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. L. Trabert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Artie E. Botts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Gertrude A. Trabert

(Address) 613 S. Bentalou St

15 Filed AUG 13 1924 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Aug 10, 1924, that I last saw h[illegible] alive on Aug 10, 1924, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

8 ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

8/13, 1924 (Signed) E. Hilles Hemming, M. D. (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug. 14 1924

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89419

CERTIFICATE OF DEATH

1-PLACE OF DEATH M. T. V. Bay View Hospital 21 Registered No.....

City of BALTIMORE: (No. ..... Balto. ..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Nicholas Demetrian

(a) Residence No.... 1712 Thames St. ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2 | 14 | 1899

7-AGE. 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)..... 186

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Greece

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Greece

14- (Informant)..... Hospital Records

(Address).....

15- Filed AUG 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 10th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 19 1924 to July 10 1924, that I last saw h.im alive on July 10 1924, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Advanced Pulmonary Tuberculosis

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis Clin. & Lab. findings.

(Signed) J. DeWitt ..... M. D.

, 19 (Address) St. B. Hosp. Bay View.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery — DATE OF BURIAL. Aug. 13 1924

20-UNDERTAKER. Geo. J. Ruth — ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Trans 1500 N. Illinois St ✓

D 89420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89420

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 225 S. Mount St., Ward) 0 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louis Proctor

(a) Residence No. 225 S. Mount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ✓ ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 9th 1923

7-AGE. ~~1~~ yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md.
(State or Country)

PARENTS.

10-NAME OF FATHER. John Proctor

11-BIRTHPLACE OF FATHER (city or town) Mount Holly
(State or Country)

12-MAIDEN NAME OF MOTHER. Carrie Henry

13-BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or Country)

14- (Informant) Carrie Henry

(Address) 225 Mount St.

15- AUG 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 6 1924 to Aug 11 1924

that I last saw him alive on Aug 11. 1924

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E. Travers M. D.

, 19 (Address) 500 Dolphin St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
Loudon Park	Aug 15 24
20-UNDERTAKER.	ADDRESS
F. B. Wiseheart	1850 W. Balto St

R. 2—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89421

CERTIFICATE OF DEATH.

D 89421

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2677 Frederick St., ... Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frieda Kolb

(a) Residence No. 2677 Frederick St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 30 1896

7-AGE 28 yrs. 4 mos. 17 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Wm H. Kolb

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Anna A. Lippert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Md.

14- (Informant) Wm H. Kolb

(Address) 2677 Frederick St

AUG 7 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 11 - 1924

17- I HEREBY CERTIFY, That I attended deceased from April 28 19 24 to Aug 11 19 24

that I last saw h. alive on Aug 11 19 24

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thomas Johnson M. D.

1924 (Address) 1001 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL, Aug 14th 1924

UNDERTAKER. F. B. Rappert

ADDRESS 1850 N Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89422 ✓ D 89422

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 Laurens ST., WARD) 17

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Fisdell

(a) RESIDENCE NO. 538 Laurens ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 2, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	35	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thos. Dobbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER — Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lula Nelson

(Address) 538 Laurens St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

G 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12. 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 1924 to Aug 12th 1924

that I last saw h.r alive on Aug 7th, 1924,

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cul. rubrens —

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) R. E. Ellis, M. D.

8/12, 1924 (Address) 924 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery

DATE OF BURIAL 8-16 1924

20 UNDERTAKER George T. A. Gibson

ADDRESS 1735 Druid Hill Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112

D 89423

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Ramsay ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Edwards

(a) RESIDENCE NO. 729 Ramsay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Sgl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/3/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Michael Edwards

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Clara Vogt

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Michael Edwards.
(Address) 729 Ramsay St

15 Filed AUG 13 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 8/13

16 DATE OF DEATH (month, day, and year) 8/13/1924

17

I HEREBY CERTIFY, That I attended deceased from 8/8/, 1924, to 8/13/24, 19,

that I last saw h— alive on 8/12/24, 19,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 1½ ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Irvin Fleming, M. D.

8/14, 19 24 (Address) 410 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	8/13 1924

20 UNDERTAKER E. Fleming & Son ADDRESS 1938 E Lafayette

AUG 13 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89424

CERTIFICATE OF DEATH.

43

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Forest St St., ... Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Quinn

(a) Residence No. 705 Forest St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Martin F. Quinn

6-DATE OF BIRTH (month, day and year) June 12 1864

7-AGE. 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS:

10-NAME OF FATHER. Harry Daly

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Harteson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

11- (Informant) Martin F. Quinn

(Address) 705 Forest St

15- Filed ..... 1924 Robert P. Harrison, Registrar.

AUG 13 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 12/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1924 to Aug 12 1924

that I last saw h.. alive on Aug 11 1924,

and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Jaw & throat

(Duration) last 4 mos. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) 1 week yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas O'Donovan M. D

Aug 13, 1924 (Address) 5 E. Read St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem	Aug 15, 1924
20-UNDERTAKER.	**ADDRESS**
Frank A. Fink	910 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89425

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH Found in water foot of

CITY OF BALTIMORE: (No. Wolfe ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson F. Francis

(a) RESIDENCE NO 3025 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Ella Francis

6 DATE OF BIRTH (month, day, and year) Mar 28 9/77

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bro R Re

9 BIRTHPLACE (city or town) (State or country) Penn Geo Francis

PARENTS

10 NAME OF FATHER Geo Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) U S

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Wm C Wigley
(Address) 3025 Elliott St

15 Filed AUG 13 1924, 192 Robert F. Garrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found on Aug 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(duration) ~~1~~ odd days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Ruloff, M. D. (Coroner.)

Aug 13, 1924 (Address) 700 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Aug 14 1924

20 UNDERTAKER Peter Nicolaus 2060 Eastern Ave — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89426

CERTIFICATE OF DEATH. X 44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., ... WARD)

2-FULL NAME Henry Maenner

(a) RESIDENCE NO. Mace Ave., Stemmers Run ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude B. Maennes.

6 DATE OF BIRTH (month, day, and year) Jan 21-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenters shop

(b) General nature of industry, business, or establishment in which employed (or employer) st.

(c) Name of employer Bethlehem Steel Corp.

9 BIRTHPLACE (city or town) Balto co

(State or country) md.

PARENTS

10 NAME OF FATHER Lawrence J. Maenner

11 BIRTHPLACE OF FATHER (city or town) Ger.

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Seing.

13 BIRTHPLACE OF MOTHER (city or town) Ger.

(State or country)

14 Informant Gertrude B. Maenner

(Address) Mace Ave. Stemmers Run

15 Filed AUG 13 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11 1924

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to August 11, 1924, that I last saw him alive on August 11, 1924, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Myocard. Insufficiency

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) — yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical and chemical

(Signed) Geo. B. Lybert, M. D.

8/11, 1924 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph's Cem. DATE OF BURIAL Aug 14 1924

20 UNDERTAKER Lilly & Zeller ADDRESS 4038 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89427 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89427

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No.) 135 W Camden St., Ward) 11

2-FULL NAME... Concetta M Scardino (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.... 135 W Camden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 14-1901

7-AGE 23 yrs. 6 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... House work
(b) General nature of industry, business, or establishment in which employed (or employer)... None
(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Calogero Scardino

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Josephine Seno

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Mr. Calogero Scardino
(Address) 135 W Camden St.

15- Filed AUG 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 12-1924

17- I HEREBY CERTIFY, That I attended deceased from 7-12-, 1924 to 8-12, 1924

that I last saw h[illegible] alive on 8-12, 1924

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endo-
carditis & myocar-
ditis-

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis &
Endocarditis (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Bruner M. D.

8-13 1924 (Address) 1604 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Aug 16 1924

20-UNDERTAKER. John J Cooney & Son ADDRESS 907 Hollins St.

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 13 1924

Spec.—1-10-21—M&T—1500 Bks.

D 39428 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39428

CERTIFICATE OF DEATH. 49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen Hosp ST., WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Gradley

(a) RESIDENCE No. 623 Fulton Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Chas Gradley

6 DATE OF BIRTH (month, day, and year) Aug 27, 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Chas Gradley (deceased)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hart (deceased)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Chas. Gradley

(Address) 623 Fulton Ave.

AUG 13 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to Aug 11, 1924, that I last saw him alive on Aug 11, 1924, and that death occurred, on the date stated above, at 4.00 p m.

The CAUSE OF DEATH* was as follows:

Suppurating carcinoma of urinary bladder

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jno Cradle Ryan M. D.

, 19 (Address) 1307 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 14th 1924
20 UNDERTAKER	ADDRESS
Leo G. Cook	North & Harford Ave

S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 188-003 D 89429

D 89429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles & Gettysburg ST., WARD)

2-FULL NAME John Isaac Johnson

(a) RESIDENCE No. 22 Kelly Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	C	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Virgie Johnson

6 DATE OF BIRTH (month, day, and year) Dec 7-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~28~~	31	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant
(b) General nature of industry, business, or establishment in which employed (or employer) Cook
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benjamin Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mary M Grant
(Address) 203 Rockaway

15 Filed AUG 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Auto Accident

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) John Norris M. D.
(Coroner.)

Aug 13 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Park DATE OF BURIAL Aug 12 1924

20 UNDERTAKER Edw Roy Stiffler ADDRESS 1215 E Mott

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Doyle

D 89430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89430

CERTIFICATE OF DEATH. 1/4-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 308 S. Gilmor St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine F. Doyle,

(a) Residence No. 308 S. Gilmor St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. 6 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug. 6. 1883.

7-AGE. 41 yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Operator

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER, Michael Doyle.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Roscommon Ireland.

12-MAIDEN NAME OF MOTHER, Katherine Hanley,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Texas. Balto Co Md.

14- (Informant) Martin L. Doyle,

(Address) 1211 Bank Gloss St.

15- Filed AUG 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 5th, 19 24 to Aug. 12, 19 24, that I last saw h.r alive on Aug. 12, 19 24, and that death occurred, on the date stated above, at 3 P t.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Primary)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Chas Norton, M. D.

8/13/24 (Address) 888 N. Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Mem Gdns DATE OF BURIAL, Aug 14, 19 24

20-UNDERTAKER, Harry Hurwitz ADDRESS 1320 W Lee

WHILE PLAINLY WRITING UNDERLINE ENTIRE NAME OF DISEASE CAUSING DEATH, AND ALL OTHER IMPORTANT ITEMS. Answers should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89431

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 1233 N. Caroline St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Dressel

(a) RESIDENCE No 1313 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Adam Dressel

6 DATE OF BIRTH (month, day, and year) Dec 28/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Sebastian Bessel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Doretha Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. L. Dressel (Address) 1313 N Central Ave

15 Filed AUG 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv. Insufficiency
(Mitral)

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Kellam, M. D.
(Coroner.)

8/14/24, 192 (Address) 598 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death....yrs.,....mos.,....ds. In the State....yrs.,....mos.,....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jordan Park Cemetery — DATE OF BURIAL Aug 16 1924

20 UNDERTAKER Penny Hoge Son — ADDRESS 309 E Eager St

IF DEATH OCCURRED IN BALTIMORE CITY, INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89432

CERTIFICATE OF DEATH. 188-003

D 89432

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

2-FULL NAME Oscar L. Mallon

(a) RESIDENCE NO 1929 Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Nov 8/1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Easton Md.

PARENTS

10 NAME OF FATHER: Chas. F. Mallon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Leona A. Saxton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Easton Md.

14 Informant: Chas. F. Mallon (Address) 1929 Patterson Park Ave

15 Filed AUG 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull- Accidental
Struck by automobile
(Inquest to be held Aug 14/24)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature], M. D.
(Coroner.)
8/13/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 15th 1924

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89433

CERTIFICATE OF DEATH.

7/4-001 D 89433
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2440 N. Bolton ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Haring

(Residence in Baltimore: No. 2440 N. Bolton. St.; 80 yrs., 5 mos. 1 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 12 (Day), 1844 (Year)

7-AGE, 80 yrs. — mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Retired) Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) (Heating Plant)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John F. Haring

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Barbara Rudolph

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A L Haring

(Address) 2446 W Baltimore St

15-

Filed AUG 14 1924 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 13 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1923, to August 13 1924, that I saw h[illegible]live on August 12 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Uremia - Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) 11 yrs. mos. 14 ds.

(Signed) E. J. Marx M. D.

8-13-, 1924 (Address) 801 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, August 15, 1924

20-UNDERTAKER George Schilling & Sons

ADDRESS 126 E Monument St

Cor.—1-12-23—M&T—100 Bks.

39434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 167-001

D 39434

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 816 Greenmount Ave. ST., WARD 10

2-FULL NAME Dora Schroeders.

(a) RESIDENCE NO. 816 Greenmount Ave. ST., WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced (or) WIFE of Franz Schroeders.

6 DATE OF BIRTH (month, day, and year) January 5th. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Lauf.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Sadonia Grafe.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant May Kunneke. (daughter)
(Address) 816 Greenmount Ave.

Filed AUG 14 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Aug. 12, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Aug. 14 1924

20 UNDERTAKER J. C. Wiedefeld — ADDRESS 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89435

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 26 N. Appleton St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick J. Scheufele

(a) Residence No. 26 N. Appleton St., Ward.....

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary Emrich

6-DATE OF BIRTH (month, day and year): March 4 1861

7-AGE: 63 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor work

(b) General nature of industry, business, or establishment in which employed (or employer): City of Baltimore

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: John Scheufele

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Mrs. H. Scheufele

(Address) 26 N. Appleton St.

Filed AUG 14 1924, 192.. ROBERT R. KRAUTH, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1920 to Aug. 14, 1924.

that I last saw him alive on Aug 14, 1924

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John V. Kvolahan M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Weston Cemetery

DATE OF BURIAL: Aug. 16, 1924

20-UNDERTAKER: John F. Cowan Son

ADDRESS: Gay & Holliday

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89436

CERTIFICATE OF DEATH.

112

D 89436

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3014 E Fayette ST., 6 WARD)

2-FULL NAME Geo. H. Engers, Jr.

(a) RESIDENCE NO 3014 E Fayette ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George T. Engers

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna M. Krude

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant George T. Engers.
(Address) 3014 E. Fayette St.

15 Filed AUG 14 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: AC Indigestion over 1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy (duration) yrs. mos. ds.

(Signed) Geo Claude Blades M. D.
(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Aug. 14th 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Burial Permit should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89437

CERTIFICATE OF DEATH.

147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary King

(a) RESIDENCE NO. 718 N. Mount ST., WARD 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence King

6 DATE OF BIRTH (month, day, and year) ~~Common~~ 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Ringold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Chas King Husband

(Address) 718 N. Mount St.

15 Filed AUG 14 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar) Mrs

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1924, to Aug 11, 1924

that I last saw her alive on Aug 11, 1924

and that death occurred, on the date stated above, at 7.00 p.m.

The CAUSE OF DEATH* was as follows:

Septisemia (Streptococcus) arising from thrombo-phlebitis following childbirth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) E Cullen Cullen M. D.

8/12 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery.

DATE OF BURIAL Aug 11 1924

20 UNDERTAKER James H. Dennis

ADDRESS 1803 Presstman St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89438

CERTIFICATE OF DEATH.

113

Registered No. D 89438

1-PLACE OF DEATH

City of BALTIMORE: (No. 952 N. Chester St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Cecilia Capa

(a) Residence No. 952 N. Chester St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Oct 8/03

6-DATE OF BIRTH (month, day and year) Oct 22 1923

7-AGE. ....yrs. 10 mos. 6 ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Franz Capa

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Josephine Kriecka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant). Franz Capa

(Address) 952 N. Chester

15- Filed ....., 192.... Registrar.

HUBERT R. KNAUSS
Burial Permit Clerk.

AUG 14 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 13 '24

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1924 to Aug 12 1924

that I last saw h.. alive on Aug 12 1924

and that death occurred, on the date stated above, at 3 30 A M.

The CAUSE OF DEATH* was as follows:

acute Ileo Colitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Infancy

Did an operation precede death? No Date of .....

Was there an autopsy? No findings

What test confirmed diagnosis? .....

(Signed) Fred Lovitch M. D.

Aug 13 1924 Address 600 N. Bath St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Aug 14 1924

20-UNDERTAKER. Frank Enoch Son — ADDRESS 1906 Eastern Ave

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89439

CERTIFICATE OF DEATH

65-102 D 89439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hos ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lane Howard

(a) RESIDENCE NO. Roanoke Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Flood Va
(State or country)

PARENTS

10 NAME OF FATHER albert J. Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna

12 MAIDEN NAME OF MOTHER Jennie E Lane

13 BIRTHPLACE OF MOTHER (city or town) Flood co Va
(State or country)

14 Informant Mrs A. J. Howard
(Address) 2400 Roanoke Va

15 AUG 14 1924 19

ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1924

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 19 24, to Aug 13, 19 24,

that I last saw him alive on Aug 13, 19 24,

and that death occurred, on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of gland

(Signed) Ken Harris, M. D.

8/14 1924 (Address) J.H.H. Path. Bacto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke Va

DATE OF BURIAL 8/14 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1409 Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89440

CERTIFICATE OF DEATH. 161-08

D 89440

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby Waldman

(a) RESIDENCE NO. 1631 Moreland Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-13-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Dr Wedyune

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Bluestein

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hebrew Records
(Address)

15 Filed Aug 14 1924, 19 ROBERT F. KRAUTER, Registrar
Burial Permit Clerk.

AUG 14 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1924, to Aug 13, 1924,

that I last saw him alive on Aug 13, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Baby weight 4 lbs 12 oz

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isidore D. Fry, M. D.

Aug. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Aug 15 1924

20 UNDERTAKER Jacob Levin 1439 E Balto — ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89441

CERTIFICATE OF DEATH X 74-001 D 89441

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 E. North Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold A. Mordecai

(a) RESIDENCE NO. Phil. Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary Eaton

6 DATE OF BIRTH (month, day, and year) Feb 7th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt. City Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Mordecai

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Donovan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Del

14 Informant Mrs M Henderson
(Address) 102 E North ave

15 Filed AUG 14 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) John H. Morrison M. D.
(Coroner.)
Aug 13, 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	8/14 1924
20 UNDERTAKER	**ADDRESS**
E J Fanning & Son 1938	E Lafayette

AUG 14 1924

GE should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D 89442

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89442

CERTIFICATE OF DEATH. 100-101

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Doe

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N.D.

(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address) Robert P. Harrison,

15 Filed AUG 14 1924, 19 Burial Permit Clerk. Registrar

1602

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 19 19, to 8-11, 19 24

that I last saw h.. alive on 8-11, 19 24

and that death occurred, on the date stated above, at 10:05 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Dean, M. D.

8-11, 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89443

CERTIFICATE OF DEATH. X 41

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD)

2-FULL NAME Edward Clark

(a) RESIDENCE No. 1618 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Gloucester Co. Va

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mah	Colard	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Clark

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	[redacted]	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer) Work for Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloster co va

PARENTS

10 NAME OF FATHER William Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Ezra Johnson

(Address) 1614 N Gilmore St

15 Robert P. Harrison, Registrar

OG 1 4 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12 1924

17 I HEREBY CERTIFY, That I attended deceased from 7/31 1924, to 8/12, 1924, that I last saw him alive on 8/12, 1924, and that death occurred on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerating Toxemia

Infected wound (Corn)

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. mos 10 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/1/24

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy findings

(Signed) Clewell Howell, M. D.

(Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gloucester Co Va — DATE OF BURIAL: Aug 13/1924

20 UNDERTAKER: Robert W Williams — ADDRESS: 1515 McCulloh St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89444

CERTIFICATE OF DEATH. 58-001

D 89444

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Fremont ST., WARD 11

2-FULL NAME William C. Smith

(a) RESIDENCE NO. 521 Fremont ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	57	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant-Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Nathaniel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Kent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wallace L. Smith
(Address) 524 W. Lafayette Ave

15 Robert P. Harrison, .19.....
Registrar
Burial Permit Clerk.

JG 1 4 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1924, to Aug 12th, 1924, that I last saw h alive on Aug 12th, 1924, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pneumonia Abscess

(duration) Part 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cyanosis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eastern, M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Aug. 15 1924

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 89445

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Charles Parrish

(a) Residence No. 827 Willow St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or ~~Divorced~~ HUSBAND ~~of (or) WIFE of~~ Alice Maud

6-DATE OF BIRTH (month, day and year) Aug 9, 1875

7-AGE. 49 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Street Cleaning
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS.
10-NAME OF FATHER, [illegible] Parrish
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(Informant) Municipal Hospital Records
(Address) Balto Md

15-AUG 14 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-12-24

17- I HEREBY CERTIFY, That I attended deceased from 8-11, 1924, to 8-12, 1924 that I last saw h— alive on 8-12, 1924 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

[redacted]; Hypertension, Chronic Nephritis; Acidosis; Pulmonary Edema; Myocardial Failure

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude S. Drake M. D.

8-13, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug 15, 1924

20-UNDERTAKER. Wm. Levering & Son Co. ADDRESS Lex. & Howard Sts

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89446

CERTIFICATE OF DEATH.

44

D 89446

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Pacca ST.; WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Mary Sanders

(Residence in Baltimore: No. 602 S. Pacca St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, October 30th, 1854
(Month) (Day) (Year)

7-AGE 69 yrs. 9 mos. 14 ds. | If LESS than 1 day ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (at home)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Barlow Van Wyck

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Rachel Van Wyck

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Vogt

(Address) 602 South Paca St

15-

Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk.

AUG 14 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1921, to Aug 13th 1924, that I saw h.. alive on Aug 13th 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cachexia of Starvation Substance

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) W. B. Tutor House M. D.

Aug 14, 1924 (Address) 1901 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hayden | DATE OF BURIAL, Aug. 16, 1924

20-UNDERTAKER Wm Cook | ADDRESS 502 E Fath

d. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.—Every item of information should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D 89447 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89447

CERTIFICATE OF DEATH. 100 – 001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

2-FULL NAME Theresa Le Hewitt

(a) RESIDENCE NO. 4615 Park Heights ST., N WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Hewitt

6 DATE OF BIRTH (month, day, and year) Sept 3, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (City or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER James Davidson Lyle

11 BIRTHPLACE OF FATHER (city or town) Chesterfield (State or country) County, Virginia

12 MAIDEN NAME OF MOTHER Josephine Tylor

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Virginia

14 Informant Municipal Hospital Records

(Address) Baltimore, Maryland

15 Filed AUG 14 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-14, 1923, to 8-13, 1924.

that I last saw h[illegible] alive on 8-13, 1924

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sat .....

(Signed) Claude A. Bruce, M. D.

(Address) Municipal Hospital 8-14 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cem	Aug 16" 1924
20 UNDERTAKER Joseph B. Cook	ADDRESS 4003 W. Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89448

D 89448

CERTIFICATE OF DEATH. X 33

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt St., 11 WARD)

2-FULL NAME Rodger D. Ryan

(a) RESIDENCE No. Maryland General Hospital St., WARD Tarantum Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 days. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 13, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Wm Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lynchburg Va

12 MAIDEN NAME OF MOTHER Miriam Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Wm Ryan 410 E-10th Ave

15 Filed OCT 4 1924 Robert P. Harrison Registrar

Tarantum Pa

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-24

17 I HEREBY CERTIFY, That I attended deceased from 8-7-24, 19..., to 8-13-24, 19..., that I last saw him alive on 8-13-24, 19..., and that death occurred, on the date stated above, at 4:25 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pneumonitis

(duration) (?) yrs. ? mos ... ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jos A Tompkins, M. D.

8-13-24 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Aug. 15" 1924

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 W. Balto St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89449

CERTIFICATE OF DEATH. 146

D 89449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cunningham

(a) RESIDENCE NO. 910 Linden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Hospital Record. (Address)

15 Filed AUG 15 1924 Burial Permit Clerk.

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1924, to Aug 13, 1924, that I last saw h[illegible] alive on Aug 13, 1924, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Pregnancy c Caseous placenta

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Gall Bladder Dis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 2-24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Nilson M. D.

, 19 (Address) Emerson Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem DATE OF BURIAL 8/15/24

20 UNDERTAKER: Daniel Easton ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89450

CERTIFICATE OF DEATH.

31

D 89450

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 509 Bloom St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther James

(a) Residence No. 509 Bloom St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, ~~Single~~ Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 22, 1907

7-AGE, 17 yrs. 3 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, James James

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), N. C.

12-MAIDEN NAME OF MOTHER, Carrie Norman

13-BIRTHPLACE OF MOTHER (city or town) Peuna (State or Country),

14- (Informant) Carrie James

(Address) 509 Bloom

15- Filed AUG 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924 to Aug 13 1924

that I last saw h.. alive on Aug 13 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

8/13, 1924 (Signed) H S McCaul M. D.

(Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount — DATE OF BURIAL, 8/15, 1924

20-UNDERTAKER, James D Kemsley — ADDRESS 578 Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 89451

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 Greenmeadow St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sams

(a) Residence No. 617 Greenmeadow St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sams

6-DATE OF BIRTH (month, day and year) 1849

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Martha Sabourn

(Address) 318 N. Gay St. City

15- Filed AUG 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1924 to Aug 12 1924

that I last saw her alive on Aug 12 1924

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) acute nephritis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. R. Caburn, M. D.

, 19 (Address) 103 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
M. E. Cemetery	8/15, 1924
20-UNDERTAKER.	ADDRESS 578
Samuel Hemsley	Hamden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89452

CERTIFICATE OF DEATH.

129 ✓ D 89452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Bond alley ST., WARD 17)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fowlands

(a) RESIDENCE NO 814 Bond alley ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Marr ✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Fowlands

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Fowlands
(Address) 814 Bond alley

15 AUG 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart Disease —

(duration) ... yrs. ... mos. ... ds.

(Signed) W K Fowler, M. D. (Coroner.)

8-13, 1924 (Address) 117 N Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 15 1924
20 UNDERTAKER Brown Fowlands	ADDRESS 1140 Edmondson Ave

N. B.—WHITE PAPER, BLACK CHARACTERS. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 89453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 89453 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Madison Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vonblier Raiff

(a) Residence No. 1600 Madison Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? 3 yrs. 3 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1921

7-AGE. 3 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Raiff

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Annie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Ada Radiff

(Address) 1600 Madison Ave

15- Filed AUG 15 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 14-24

17- I HEREBY CERTIFY, That I attended deceased from August 13 1924 to August 14 1924

that I last saw her alive on August 13 1924

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Acute)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. L. W. Kennard M. D.

8-14 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	Aug 14 1924
20-UNDERTAKER.	**ADDRESS**
Brown & Freland	114 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89454

CERTIFICATE OF DEATH.

D 89454

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 E. Mt Vernon Place ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Isabel White

(a) RESIDENCE. NO. 27 E. Mt Vernon Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-9-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER B. F. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Eva Stiltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Mrs. M. L. Derrickson Balto Md

15 Filed AUG 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1924, to Aug 13, 1924, that I last saw her alive on Aug 12, 1924, and that death occurred, on the date stated above, at 7:0 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. H. Jenkins M. D.

8.13. 1924 (Address) 119 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Baltimore Md	Aug 15 1924
20 UNDERTAKER W. M. Rowlson	ADDRESS 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89455

CERTIFICATE OF DEATH.

D 89455

90

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Whelan

(a) RESIDENCE NO 1710 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) November 1st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) United Railways
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Geo. W. Whelan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Haupt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Miss Mary E. Whelan (sister)
(Address) 1710 N. Fulton Ave

15 AUG 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Dilatation
(Probably Valv. Insufficiency)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Wales (Coroner), M. D.
8/14/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Aug 16 1924

20 UNDERTAKER John O Mitchell — ADDRESS 1201 W Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 89456

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1624 Enton Place ST., ... WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estelle Haines

(a) RESIDENCE No. 1624 Enton Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Haines

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo W Mistic

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Ruth Taylor
(Address) 921 W Lafayette Ave

15 Filed AUG 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

About (duration) 40 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history (duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. E. Hennebery, M. D. (Coroner.)

Aug. 14, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tranaients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Aug 15 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Pratt Ave

N. B.—WHITE PAPER, WITH CREASING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89457

CERTIFICATE OF DEATH.

89 D 89457.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2017 N. Lanvale ST., ... WARD)

2-FULL NAME Bric J. Worthington

(a) RESIDENCE NO. 2017 N. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary R Worthington

6 DATE OF BIRTH (month, day, and year) Oct 24. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	9	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer B. R. R.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Amos D Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet D Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amos D Worthington
(Address) 2017 N. Lanvale St

15 AUG 15 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history (duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Aug. 14, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel. DATE OF BURIAL Aug 16 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Monument

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 89458 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89458

CERTIFICATE OF DEATH.

101-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 W.Stricker St. ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bias

(a) RESIDENCE. No. 1340 W.Stricker St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	4	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Pressing clothes

(c) Name of employer Self.

9 BIRTHPLACE (city or town) West River
(State or country) Md.

PARENTS

10 NAME OF FATHER William Byers.

11 BIRTHPLACE OF FATHER (city or town) Anne
(State or country) Md. Arundel Co.

12 MAIDEN NAME OF MOTHER Gertrude Randall

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Md.

11 Informant Gertrude Brown
(Address) 1340 Stricker St.

15 Filed AUG 15 1924 ROBERT H. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8 1924, 19, to Aug. 11 1924 192, that I last saw h im alive on Aug. 11 1924, 19, and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death EH.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptom

(Signed) Charles E. Clark, M. D.

8-12-24 (Address) 1306 N. Gilmor st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Aug 14, 1924
20 UNDERTAKER	ADDRESS
Mr & James H. Dennis	1303 Preastman St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89459

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3320 Foster Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward R. Coleman

(a) Residence No. 3320 Foster Ave St., 26 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 29-1923

7-AGE. 1 yrs. 2 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. city.

PARENTS.

10-NAME OF FATHER, Edward. Colrman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER, Rena V. Causey.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Co Md.

14- (Informant) Edward. Colrman

(Address) 3320 Foster Ave.

15- AUG 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 13-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12 1924 to Aug 13 1924

that I last saw him alive on Aug 12 1924

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ... yrs. ... mos. 3 ... ds.

CONTRIBUTORY (Secondary) Eclampsia

(Duration) ... yrs. ... mos. 1 ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) M J McAvoy M. D

Aug 14 1924 (Address) 839 S. Edwards

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Sacred Heart.	Aug 15 1924
20-UNDERTAKER, Lilly Ed Zeiler	ADDRESS 1038 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 16-102 D 89460

REGISTERED NO. .....

1-PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33 rd ST., WARD) W

2-FULL NAME Elmer Alexander Grover

(a) RESIDENCE No. Belair, Md ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 hrs. ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Belair, Md.

PARENTS

10 NAME OF FATHER James E. Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francina Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James E. Grover

(Address) Belair, Md.

15 AUG 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1924, to Aug 14, 1924, that I last saw him alive on Aug 14, 1924, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Belair, Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Donald C Chandler M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Belair Md.

DATE OF BURIAL 8-15 1924

20 UNDERTAKER E & B Hahn

ADDRESS 115 E Mount St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89461

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Schley ave St., 27 Ward) near Southern Av

Registered No. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theador Harman Brenneman

(a) Residence No. Schley ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) August 9/24

7-AGE. — yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Russel Brenneman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Bertha E. Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant). Russel W. Brenneman

(Address) Schley ave.

15- AUG 15 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/13/24

17- I HEREBY CERTIFY, That I attended deceased from 8/11 1924 to 8/13 1924 that I last saw him alive on 8/13 1924 and that death occurred, on the date stated above, at 5.30 A.M. The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asthenia V. Heart failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical & symptoms

(Signed) Harry D. Rustkopf M. D.

8/15 1924 (Address) 1618 E. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Country. DATE OF BURIAL. Aug 16 1924

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Hayford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89462 — 114 — D 89462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 N Port St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F Koenig

(a) RESIDENCE NO. 1718 N Port St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna R. Koenig

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1886

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	9	21	

8 OCCUPATION OF DECEASED Card Refiner

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lizetta Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna R. Koenig (Address) 1718 N. Port St.

15 Filed AUG 15 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/1924

17 I HEREBY CERTIFY, That I attended deceased from 8/5/24, 19..., to 8/13/24, 19..., that I last saw h.. alive on 8/13/24, 19..., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

..... (duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

..... (duration) ... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Theodore Davis M. D.

, 19 (Address) 1727 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 16 1924

20 UNDERTAKER Furkler & Furkler — ADDRESS 1137 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89463

D 89463

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Julia J. Mauer

(a) RESIDENCE NO. 1233 N Carlton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ (HUSBAND) of (or) WIFE of Mrs Mauer

6 DATE OF BIRTH (month, day, and year) Jan 10-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 37
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Sabastian Bassel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Madgline Ach

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Julia J Mauer Niece
(Address) 1233 N Carlton St Phila

15 Filed AUG 15 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) yrs. 1 mos. ds.

(Signed) W K Gorsuch, M. D. (Coroner.)

8-15, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 16 1924
20 UNDERTAKER Robt J Turner Jr	ADDRESS N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89464

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 322 E. 28th. St., Ward.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine G. Stack

(a) Residence No. 322 E. 28th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6-DATE OF BIRTH (month, day and year): Do not know

7-AGE: 70 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: John Stack

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Ellen Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Jerome T. Stack

(Address): 2923 St. Paul St.

15- Filed ....., 19.....

Robert P. Harrison, Registrar.

AUG 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to August 14, 1924

that I last saw h[illegible] alive on August 14, 1924

and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis —

unknown —

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) unknown ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldborough, M. D.

, 19 (Address) 2923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL, 8/16, 19 24

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89465

CERTIFICATE OF DEATH.

113 D 89465

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 S. Bond Street St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Feliks Kozieracki

(a) Residence No. 808 S. Bond Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 26 1924

7-AGE. ....yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Stanislaus. Kozieracki

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Helen . Skladanek

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country),

14- (Informant) Mr. Stanislaus. Kozieracki
(Address) 808 S. Bond Street

15- Filed Robert P. Harrison, Registrar.

AUG 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15/24

17- I HEREBY CERTIFY, That I attended deceased from 8/10 1924 to 8/15 1924

that I last saw h[illegible] alive on 8/15 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & also colitis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Heart failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N O Date of

Was there an autopsy? N O

What test confirmed diagnosis?

(Signed) Jay D Dunkoff M. D

8/15 1924 (Address) 1623 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL, August 16 1924

20-UNDERTAKER. John McWeber — ADDRESS 1803 Bank st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89466

CERTIFICATE OF DEATH.

10

D 89466

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST., WARD)

2-FULL NAME Barbara Wiley

(a) RESIDENCE No. 1200 S. Ellwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	1	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Wiley

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Hallie Wisniewski

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant (Address) Mrs. R. Wiley 1200 S. Ellwood Ave

15 AUG 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 14 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to aug 14, 1924, that I last saw her alive on August 14, 1924, and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal, tonsillar, pharyngeal (duration) — yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) Blackman, M. D.

(Address) Sydenham Hospital aug 14 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Thomas Cem	Aug 18 1924
20 UNDERTAKER	ADDRESS
Stephen F. Trachowski	1033 Hollins Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89467

CERTIFICATE OF DEATH.

D 89467

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 660 W Franklin ST., WARD)

2-FULL NAME Mrs Lilian Katzenberger

(a) RESIDENCE NO. 660 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Katzenberger

6 DATE OF BIRTH (month, day, and year) June 8, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sam Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. R B Emslie (Address) 1660 W Franklin

15 AUG 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Aug 14, 1924.

that I last saw h alive on Aug 14, 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Brights (duration) 1 yrs. 8 mos 3 ds.

CONTRIBUTORY (Secondary) none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) R B Emslie M. D.

Aug 8, 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Aug. 16 1924 — DATE OF BURIAL

ADDRESS

20 UNDERTAKER Wm Cook & Sons

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89468

CERTIFICATE OF DEATH.

129

D 89468

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 611 N. Pulaski ST., 15 WARD 16

2-FULL NAME David Wellington Chambly.

(a) RESIDENCE NO. 611 N. Pulaski St ST., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? 73 yrs. 9 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona V. Chambly.

6 DATE OF BIRTH (month, day, and year) Oct. 15 - 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	28da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Planer

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Manufacture

(c) Name of employer Himmel & Son

9 BIRTHPLACE (city or town) (State or country) Raleigh N. C.

PARENTS

10 NAME OF FATHER Riley Chambly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? North Carolina

12 MAIDEN NAME OF MOTHER Mary E. Pugh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Virginia

14 Informant Leona V. Chambly. (Wife)

(Address) 611 N. Pulaski St.

15 Filed ..... 19 ..... Robert F. Garrison, Registrar

Burial Permit Clerk.

OG 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1924.

17 I HEREBY CERTIFY, That I attended deceased from August 8 - 1924. to August 12 - 1924.

that I last saw him alive on August 11 1924.

and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Chester Riland., M. D.

8-12. 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL Aug 16 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. [illegible] St.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89469

D 89469

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 517 S. Durham St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Grabowska

(a) Residence No. 517 S. Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 12 1924

7-AGE. .....yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS:

10-NAME OF FATHER, Walter Grabowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Helen Lawicki

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Walter Grabowski

(Address) 517 S. Durham St.

15- AUG 5 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1924 to Aug. 15, 1924, that I last saw h[illegible] alive on Aug. 13 1924, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Marasmus followed with Ileo-Colitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 2 mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? P S & S.

(Signed) John J. Kregen M. D.

, 19 (Address) 2627 Elsten Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St. Stanislaus	Aug. 16, 1924.
20-UNDERTAKER.	**ADDRESS**
W. F. Sadowski	705 S. Ann

Burial Permit Issued

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89470

D 89470

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame College ST., 27th WARD)

2-FULL NAME Mary Louis Fuchs

(a) RESIDENCE NO. Charles Street Ave ST., 27th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Notre Dame College

9 BIRTHPLACE (city or town) Syracuse
(State or country) New York

PARENTS

10 NAME OF FATHER Louis Fuchs

11 BIRTHPLACE OF FATHER (city or town) Prussia
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Nunold

13 BIRTHPLACE OF MOTHER (city or town) Bavaria
(State or country) Germany

14 Informant Sister M. Philomena
(Address) Charles Street Ave. Balto.

Filed AUG 15 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924 to Aug 14, 1924, that I last saw h alive on Aug 14, 1924, and that death occurred, on the date stated above at 5 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

+ Pleurisy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma of Pleura beginning in Breast

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Amputation + Breast Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Chas Hamner, M. D.

19 24, 19 (Address) 47 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govens town Prevate	Aug 16 1924
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Uninformation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89471

CERTIFICATE OF DEATH.

31 D 89471

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2813 Windsor ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Riggin

(a) Residence No. 2813 Windsor ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/3/1883.

7-AGE. 41 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer.....

9-BIRTHPLACE (city or town) ..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Riggin

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Clinton

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Md.

14- (Informant) Mrs. Th. Clinton

(Address) 2813 Windsor ave

15- Filed ..... Robert P. Harrison, Registrar.

AUG 5 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). aug. 13/24

17- I HEREBY CERTIFY, That I attended deceased from July 27th 1924 to aug 12 1924

that I last saw him alive on aug 12 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Harris Friedman M. D

8/15 1924 (Address) 1816 W North av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19....
New Cathedral	8/16/24
20-UNDERTAKER.	ADDRESS
J. Baker & Sons	1315 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89472

CERTIFICATE OF DEATH.

D 89472

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 751 W. Baltimore St.; Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Krevenas

(a) RESIDENCE. No. 751 W. Baltimore St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer worked for himself

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Micheal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant J. P. Zebransky

(Address) 3407 Roland Ave

15 Filed Robert P. Harrison Registrar

Burial Permit Clerk

AUG 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug. 13, 1924,

that I last saw him alive on Aug. 12, 1924,

and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Pelvic Bones

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings.

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetary	Aug. 16 1924
20 UNDERTAKER	ADDRESS
Chas. B. Kuchinskas	687 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89473

CERTIFICATE OF DEATH.

44

D 89473

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1906 Barclay Street St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frederick Schultz

(a) Residence No. 1906 Barclay Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M.Ford

6-DATE OF BIRTH (month, day and year) Apr.19,1849

7-AGE,	If LESS than 1 day,
75 yrs. 3 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tobacco Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)..... (Retired)

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Carl Schultz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Gertrude

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Emma M.Schultz

(Address) 1906 Barclay Street

15- Filed ..... By Robert P. Harrison, Registrar.

AUG 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug.13,1924

17- I HEREBY CERTIFY, That I attended deceased from April, 1921, to Aug 13, 1924

that I last saw him alive on Aug 13, 1924,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Almost

(Signed) George H. Moore, M. D.

8-14-1924 (Address) Md. Ave. & Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cem	Aug 16, 1924
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 N Balto

CN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89474

CERTIFICATE OF DEATH.

D 89474

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 816 Wellington ST., (13 WARD)

2-FULL NAME Sarah R. McCauley

(a) RESIDENCE NO. 816 Wellington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace L McCauley

6 DATE OF BIRTH (month, day, and year) April 8-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	4	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Seymour

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Horace L. McCauley
(Address) 816 Wellington St

15 Filed AUG 16 1924 192 Robert F. Harris
Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH was as follows:
Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison, M. D.
(Coroner.)
Aug 15. 1924 (Address) 3682 Norfolk

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Aug. 16 1924

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Walbrook

R. B. WHITE BLANKS, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89475

CERTIFICATE OF DEATH.

118 D 89475

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Weidner

(a) RESIDENCE NO. 206 N. Payson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): ~~Widowed~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Chas Wm Weidner

6 DATE OF BIRTH (month, day, and year): July 26-1846

7 AGE: Years 78 Months 0 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework. 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Steubenville Ohio ~~Ireland~~

PARENTS

10 NAME OF FATHER: John F Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Pearce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Daughter (Address): 206 N Payson St.

15 Filed ....., Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1924

17

I HEREBY CERTIFY, That I attended deceased from August 12, 1924, to August 13, 1924, that I last saw her alive on August 13, 1924, and that death occurred, on the date stated above, at 9. p.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia - post Gestric

(duration) yrs. 5 hours mos ds.

CONTRIBUTORY (Secondary) Shock and intestinal Inflamation (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 12-1924

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Anatomical

(Signed) Jno A Compton M. D.

, 19 (Address) 1 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Aug 16 1924

20 UNDERTAKER: Wm J Pickus & Sons — ADDRESS: North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89476

D 89476

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S. Parrish ST. 14 WARD)

2-FULL NAME Grace L. Miller

(a) RESIDENCE. NO. 316 S. Parrish ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 5 - 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER David N. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary M. Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David Miller
(Address) 316 S. Parrish St

15 Filed AUG 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/12, 1924, to 8-14, 1924.

that I last saw her alive on 8-14-, 1924

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Anterior Poliomyelitis

(duration) yrs. mos. 3 ds?

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) S. Hellen Hemming M. D.

8/15, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 16 '24

20 UNDERTAKER Henry H. Wetzel ADDRESS 153 W Lombard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89477

CERTIFICATE OF DEATH.

118-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen Hospt St. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lippo

(a) RESIDENCE NO. 2571 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 2, 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Elmer Ray Lippo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER M. E. Southcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Elmer Ray Lippo (Address)

AUG 16 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 24 19 , to Aug 14 , 1924, that I last saw him alive on Aug 14 , 1924, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 13, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL Aug 16 1924

20 UNDERTAKER Henry W. Witzke — ADDRESS 1531 W. Lombard St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89478

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Bay View Hospital 10 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank N. Fitzgerald

(a) Residence No. 3627 Chestnut Ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) Widow of~~ Jennie Fitzgerald

6-DATE OF BIRTH (month, day and year) July 25 1876

7-AGE 52 yrs.....mos.....ds.

If LESS than 1 day ....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Bay View Hospital

(Address).....

15-Filed AUG 16 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 15, 1924

17-I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1924 to Aug 15, 1924

that I last saw h.. alive on Aug 15, 1924

and that death occurred, on the date stated above, at 11.58 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) 2 yrs. mos. 2 dys.

CONTRIBUTORY (Secondary) Acute Psychosis with Delirium Tremens

Acute Nephritis (Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Fitzsimmons M. D.

8/15/1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn	Aug 18 1924

20-UNDERTAKER. Chenoweth & Son ADDRESS 361 Chestnut Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89479

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89479

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1809 Madison Ave ST. 14 WARD)

2-FULL NAME Emily Hill

(a) RESIDENCE NO. 1809 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wm Hill

6 DATE OF BIRTH (month, day, and year) Aug. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co. La Plata Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER Adelaide Dyson

13 BIRTHPLACE OF MOTHER (city or town) La Plata (State or country) Md

14 Informant Mary Hill (Address) 1809 Madison Ave

15 Aug 6 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1924 to Aug 7 1924

that I last saw her alive on Aug. 6 1924,

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Orthosclerosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chis, M. D.

8/15, 1924 (Address) 927 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL Aug 16 24

20 UNDERTAKER Samuel Hemsley

ADDRESS W Balto

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... OCCUPATION is very important. See instructions on back of certificates.

AUG 6 1924

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89480

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 W Hoffman St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie A. Hooper

(a) RESIDENCE. No. 643 W Hoffman ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Hooper

6 DATE OF BIRTH (month, day, and year) Apr 12 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Tarbey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Mozell (Address) 643 W Hoffman St

15 Filed AUG 16 1924 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 8 1924 to Aug 13 1924

that I last saw her alive on Aug 12 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos Woolridge, M. D.

8/15 1924 (Address) 2032 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 16 1924

20 UNDERTAKER Frank Hensley ADDRESS 378 N Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89481

161-001

D 89481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 926 Risgaith St.

CITY OF BALTIMORE: (No. 926 Risgaith St. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Woods

(a) RESIDENCE NO. 926 Risgaith ST., 10 WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 Hours mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wid of F. L. Wood

6 DATE OF BIRTH (month, day, and year) aug. 15/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
Aug. 15. 1924			0 hours	0 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Fred. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Camilla Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Fred Woods 926 Risgaith St.

15 Robert P. Harrison, Registrar

AUG 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15. 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14. 24. 1924 to Aug. 15 1924, that I last saw h[er] alive on Aug. 15th. 1924, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Abortus (fifth month)

3 Hours a Life

— (duration) — yrs. mos.

CONTRIBUTORY (Secondary) Inability to live.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) J. J. Sebold, M. D.

, 19 (Address) 1001 Risgaith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rood Cemetery	Aug 16 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89482

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 225 [illegible] St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Williams

(a) Residence No. 225 [illegible] St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug-13-1915

7-AGE, 9 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), [illegible]

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), [illegible]

14- (Informant) [illegible]

(Address) [illegible]

15- Robert P. Harrison,

Registrar.

AUG 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug-14-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 14, 19 24 to Aug 14, 19 24

that I last saw h... alive on Aug 14, 19 24

and that death occurred, on the date stated above, at 2 [illegible] M.

The CAUSE OF DEATH* was as follows: 2 Pneu

Edocarditis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8-15-, 19 24 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL, Aug 18th, 19 24

20-UNDERTAKER, A J Jones

ADDRESS 111 S Gilmor St

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89483

D 89483

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (WARD)

2-FULL NAME Lawrence F. Holbrook

(a) RESIDENCE NO. Randallstown md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 2-1916

7 AGE: Years 7 | Months 9 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ab School
(b) General nature of industry, business, or establishment in which employed (or employer) pub
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Holbrook. M

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Greenwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Wm. M. Holbrook (Address) Randallstown, Md.

15 Filed AUG 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1924, to August 15 1924.
that I last saw him alive on Aug. 15, 1924,
and that death occurred, on the date stated above, at 11:15 P.m.

The CAUSE OF DEATH* was as follows:

Septicemia (Staphylococcus Aureus)

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) ..... M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Family Cem. Harrisonville Md. | DATE OF BURIAL: Aug 18 1924

20 UNDERTAKER: Horace H. Burgee | ADDRESS: 3631 Fallsway

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89484

D 89484

CERTIFICATE OF DEATH.

21

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 104 N Helton St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Malcolm Holt Green

(a) Residence No. 104 N Hilton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married,~~ ~~Widowed,~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 8/1902

7-AGE. 22 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Musician

(b) General nature of Industry, business, or establishment in which employed (or employer). do

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Washington D C

PARENTS.

10-NAME OF FATHER. Chas B Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Isabella Kearney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Brooklyn N Y

14- (Informant). Chas B Green

(Address) 104 N Hilton St

15- ....., 192.....

Registrar.

AUG 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/15/1924

17- I HEREBY CERTIFY, That I attended deceased from 4-1, 1924 to 4-1 1924 that I last saw h.. alive on 8-12 1924 and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(Duration) yrs. 1/2 mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) J. Fred Burgess M. D.

8/16 1924 (Address) 800 N Bath Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem

DATE OF BURIAL. 8/18, 1924

20-UNDERTAKER. John Ellerick

ADDRESS 2008 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89485

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1033 N. Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hebron

(a) Residence No. 1033 N. Wolfe St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of #

6-DATE OF BIRTH (month, day and year) 3-15-1918

7-AGE.	If LESS than 1 day,
6 yrs. 5 mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Baltimore Md
(State or Country).

PARENTS.

10-NAME OF FATHER. Walter Colbert

11-BIRTHPLACE OF FATHER (city or town). Not Known
(State or Country).

12-MAIDEN NAME OF MOTHER. Lillian Hebron

13-BIRTHPLACE OF MOTHER (city or town). Hampstead
(State or Country). Md

11- (Informant) Mary Hebron

(Address) 1033 N. Wolfe St

15- AUG 16 1924 Robert E. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8-13-24

17- I HEREBY CERTIFY, That I attended deceased from July 17, 1924, to Aug 13, 1924, that I last saw him alive on Aug 13, 1924, and that death occurred, on the date stated above, at 8-10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor
(Sarcoma)
Situated in occipital region
(Duration) yrs. mos 27 ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D

8-14, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery DATE OF BURIAL. aug 16th 1924

20-UNDERTAKER, Milton Davis ADDRESS 515 N Eden St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

P 38486 B

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital 100 001

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Powell

(a) RESIDENCE No. 107 S. Caroline ST. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred L yrs. F mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): July 19 1922

7 AGE — Years: 2 — Months: 1 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Elsworth Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Florence Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records Johns Hopkins Hospital

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
AUG 16 1924
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1924 to Aug 14, 1924, that I last saw her alive on Aug 14, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Thoracic Rickets

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) A. A. Reach, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Aug 16 1924

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89487

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 Fulton Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Friedberger

(a) RESIDENCE NO. 2032 Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Lazarus Friedberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) F. Goldsmith 2032 N. Fulton Ave

15 Filed Aug 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. ..., 1923, to Aug 17, 1924, that I last saw her alive on Aug 17, 19..., and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) Leonard E Beach, M. D.

, 19 (Address) 2201 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Friendship Cemetery — DATE OF BURIAL Aug 17 1924

20 UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Madison Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89488

CERTIFICATE OF DEATH.

D 89488

198

1-PLACE OF DEATH

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 15 WARD)

2-FULL NAME Branch Hopkins. (C)

(a) RESIDENCE NO. 1403 N. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 30th. 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Samuel Hopkins. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lucinda Branch. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant William Hopkins. (C) brother.
(Address) 1403 N. Mount St.

15 Filed AUG 16 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) & inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple incised wounds about head and body by short instrument.
Shock and Hemorrhage. Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Rosenhardt, M. D. (Coroner)

Aug, 14, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Barrest & May Sts. August 12, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cmtery — DATE OF BURIAL Aug 16 1924

20 UNDERTAKER Mrs Jas H. Dennis — ADDRESS 1303 Pressetman St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89489

CERTIFICATE OF DEATH.

43 D 89489

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 St Paul St ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Tucker

(a) RESIDENCE. No. 1627 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Eva Siegenaug-1862

6 DATE OF BIRTH (month, day, and year) Sept 9, 1863

7 AGE — Years: 61 — Months: X — Days: X — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mech Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Monticello - Fla.

PARENTS

10 NAME OF FATHER Jas. R. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Monticello, Fla.

12 MAIDEN NAME OF MOTHER Florence Germany

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tallahassee Fla

14 Informant (Address): A. Louise (Tucker) Hines daughter

15 Filed AUG 16 1924, 19 Registrar

Robert P. Harrison.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Aug 15, 1924, that I last saw him alive on Aug 15, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (cervix)

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 1629 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Aug 19 1924

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89490

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Division ST. 14 WARD)

2-FULL NAME Ellen M. Tighe

(a) RESIDENCE NO. 1806 Division ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John M. Tighe

6 DATE OF BIRTH (month, day, and year) June 25 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER James O'Rourke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Bessie Tighe
(Address) 2221 Barclay St.

Filed AUG 16 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
1st. 2nd & 3rd degree burns of body
about 2 hrs
(duration) ... yrs. ... mos.
CONTRIBUTORY (Secondary) Clothing caught fire accidentally by lighted stove
(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)
Aug. 16, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N. Point Cemetery	Aug 18 1924
20 UNDERTAKER Wm. Cook	ADDRESS Eastern

AUG 16 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89491

CERTIFICATE OF DEATH.

REGISTERED NO. 1502

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hosp ST., 9 WARD)

2-FULL NAME Baby Cole

(a) RESIDENCE NO. 1637-E. 37th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 13 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Thomas F. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Eva Stock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Thomas F. Cole

(Address) 637 E 37th st

15 AUG 16 1924, 19

Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 16 1924

17 I HEREBY CERTIFY, That I attended deceased from aug 13, 1924, to aug 16, 1924,

that I last saw her alive on aug 16, 1924,

and that death occurred, on the date stated above, at 6 10 a. m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

Hemorrhagic disease of the new-born

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Vomiting & Cyanosis Immediately Evident

(Signed) S. W. Kovacs, M. D.

, 19 (Address) 1813 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemty — DATE OF BURIAL: Aug 16 1924

20 UNDERTAKER: Robt J Turner Sons — ADDRESS: 1442 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89492

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89492

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Nolan

(a) Residence No. Preston E. Valley Sts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Unknown 1839

7-AGE, 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ans

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

11- (Informant) Sister Superior

(Address) Preston & Valley

15- Robert F. Harrison,

Filed ....., 192 Registrar.

AUG 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15 1924

17- I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ....., 19....., that I last saw h[illegible] alive on Aug 10, 1924, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Aug 15 1924 (Signed) J. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Aug 16, 1924

DATE OF BURIAL,

20-UNDERTAKER, H. C. Wiedefeld & Son

ADDRESS Greenmount Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89493

CERTIFICATE OF DEATH.

12 D 89493

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 S. Bouldin St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice E. Ensor

(a) Residence No. 502 S. Bouldin St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 17, 1907

7-AGE. 16 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tin Decorating Co.

9-BIRTHPLACE (city or town) Balto (State or Country) Md.

PARENTS.

10-NAME OF FATHER. Maurice E. Ensor

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country) Md.

12-MAIDEN NAME OF MOTHER. Sophie Frederick

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country) Md.

14- (Informant) Elizabeth F. Gibbs

(Address) 502 S. Bouldin St.

15- Filed AUG 16 1924 19.. Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1924 to August 13 1924

that I last saw h.. alive on August 13 1924

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 3 hours

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Effect for Nephritis

(Signed) W. D. Forde M. D

19 (Address) Corner Southern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. 1st Evangelical Lens — DATE OF BURIAL. Aug 18 1924

20-UNDERTAKER. H. Sander Sons — ADDRESS 1110 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Uehr)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89494

D 89494

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 629 Mc Cabe Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Uehr

(a) Residence No. 629 Mc Cabe Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 11. 1883

7-AGE. 41 yrs. — mos. 4 ds.

If LESS than 1 day, hrs. or..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Baker

(b) General nature of industry, business, or establishment in which employed (or employer). Md. Biscuit Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country). Md.

PARENTS.

10-NAME OF FATHER. William Uehr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elisa Ruemmele

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant) Elisa Uehr

(Address) 629 Mc Cabe Ave

15-Filed AUG 16 1924 Robert P. Griffith Registrar

Burial Permit Issued by Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1924, to Aug 15 1924,

that I last saw h[illegible] alive on Aug 15 1924

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. M. Duncan M. D

Aug 16, 1924 (Address) 5106 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cem. — DATE OF BURIAL. Aug. 18. 1924

20-UNDERTAKER. H. Sander Sons — ADDRESS. 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89495

CERTIFICATE OF DEATH.

3 129

D 89495

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James Thomas

(a) Residence No. 18 S. Bethel St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1888

7-AGE. 36 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Maryland
(State or Country).

PARENTS.

10-NAME OF FATHER, John Thomas

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..... Md.
(State or Country).

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15- Filed ..... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-13-24

17- I HEREBY CERTIFY, That I attended deceased from 7-16....., 1924 to 8-13.., 1924 that I last saw him alive on 8-12..., 1924 and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Hypertension; Chronic Nephritis; Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Thomas M. D.

8-13-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, ... 19..

20-UNDERTAKER. ..... ADDRESS .....

AUG 16 1924

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 16 1924

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89496

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Annandale Apts. St., 13 Ward) 60-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Martha Nordlinger.....

(a) Residence No..... Annandale Apts. ...3. E. St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

Pike, Penn, Allen

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Oct. 11, 1868.

7-AGE, 55 yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Isaac D. Nordlinger

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Nannette Eising

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant) Mrs. Pachalder

(Address) Annandale Apts.

15- Filed ..... 192.... Robert F. Harrison, Registrar.
Burial Permit Clerk.

AUG 16 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/16/24.

17- I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 8/16 19 24, that I last saw h. alive on 8/16, 19 24 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Disease Hypertrophy of Prostate Gland (Duration) several years. yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Theodore H. Monson M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Har Sinai Cem. DATE OF BURIAL, 8/17/24., 19....

20-UNDERTAKER, David Sondheim ADDRESS 1117 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—[illegible] Blks.

D 89497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89497

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Leadenhall St. ST., 23 WARD)

2-FULL NAME Ollie Owens. (C).

(a) RESIDENCE NO. 1020 Leadenhall St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 22, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	--	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ollie Owens. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia.

12 MAIDEN NAME OF MOTHER Mollie Bovinton (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia.

14 Informant Mollie Owens. (C) (mother)
(Address) 1020 Leadenhall St.

15 Dec 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)

Aug. 16, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	8/16 1924
20 UNDERTAKER	ADDRESS
John E. Toadvine	1027 Druid Hill Ave

AUG 16 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 89498 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1131 Druid Hill ave St., 11 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Daniels

(a) Residence No. 1131 Druid Hill ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE Colored

5-Single, Married, Widowed, Divorced (write which) Married

5a-If married, (widowed, or divorced) HUSBAND of (or WIFE of) James Daniels

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 52 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic (37)

(b) General nature of industry, business, or establishment in which employed (or employer) Duties

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland.

PARENTS:

10-NAME OF FATHER George Handy

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Caroline Warfield

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Maryland

14- (Informant) Rachel Kelly

(Address) 1131 Druid Hill Ave

15- Robert F. Harrison,

Filed AUG 16 1924 192 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 15-24

17- I HEREBY CERTIFY, That I attended deceased from August 2 – 1924 to August 15 1924

that I last saw her alive on August 14 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis & Chronic Nephritis (Duration) 1 yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. W. Kennard M. D.

8-15 1924 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Locust Lefleurs — DATE OF BURIAL: Aug. 18. 1924

20-UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39499

D 39499

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 8 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Schraudner

(a) RESIDENCE No. 2230 Henneman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) Nov 25/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md.

PARENTS

10 NAME OF FATHER Fred. Schraudner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md

12 MAIDEN NAME OF MOTHER Anna Lenhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant: Fred. Schraudner (Address) 2230 Henneman St

15 Filed AUG 16 1924, 192 Robert P. Harrison, Registrar

Central Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J S H Owen, M. D. (Coroner.)

8/15/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 16 1924
20 UNDERTAKER	ADDRESS
Paul E Crockett	100 Gilmor

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89500

CERTIFICATE OF DEATH.

D 89500

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Immigrant ST., 4 WARD)

2-FULL NAME Hope Kirkwood

(a) RESIDENCE NO. White Hall - Md Rt 2. ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hyke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) University of Maryland Hospital Balto

15 Filed Aug 16, 1924 A. Hampson Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/6/24, 19..., to 8/13, 19 24.

that I last saw him alive on 8/13, 19 24

and that death occurred, on the date stated above, at 1130 Am.

The CAUSE OF DEATH* was as follows:

Diabetis

Complicated by large Carbuncle of neck

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carbuncle

.....(duration) ..... yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8/12/24

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) J. B. Whaley M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Church Cemetery

DATE OF BURIAL Aug 18 1924

20 UNDERTAKER B. H. Kurtz & Son

ADDRESS Jarrettsville Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-007

D 89501

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 27 WARD)

2-FULL NAME James L. Lynch 3rd.

(a) RESIDENCE No. 614 Hollins St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15, 1924

7 AGE — Years — Months — Days / If LESS than 1 day 2½ hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James L. Lynch

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gabriella Lippel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant ..... (Address) 614 Hollins St.

15 Filed AUG 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Aug 16 1924, that I last saw h[illegible] alive on Aug 16 1924 and that death occurred, on the date stated above, at 7.55 [illegible] m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

21 hours.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth 21 hours

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Inspection

(Signed) Thomas [illegible] M. D.

, 19 (Address) 225 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	August 18 1924
20 UNDERTAKER	ADDRESS
Henry Hofstein & Co.	Eutaw & [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89502

CERTIFICATE OF DEATH.

23 D 89502

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Hebrew Hospital ST., 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Levin

(a) RESIDENCE No. 2004 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 — 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Abram Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Berkow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin
(Address) 1439 E Baltimore St

15 Filed AUG 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1924, to Aug 15, 1924, that I last saw him alive on Aug 15, 1924, and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows: Undetermined

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Adler Goldsmith M. D.

8/15, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Memorial Park

DATE OF BURIAL 8/17 1924

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

Cor.—1-12-23—M&T—100 Bks.

D 89503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 170

CITY OF BALTIMORE: (No. Jaybird Hospital St., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Sylvester

(a) RESIDENCE No 1602 Riverside Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R Sylvester

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U S Goverment

9 BIRTHPLACE (city or town) (State or country) Corsens N. Y.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary E. Sylvester (Address) 1602 Riverside Ave Balto Md

15 AUG 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound of Brain Self Inflicted while temporarily Insane (duration) Few Hours

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Hudgins, M. D. (Coroner.)

Aug 15, 1924 (Address) Jaybird Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos. ..... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 1602 Riverside Ave

Former or usual residence " " "

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Aug 17 1924

20 UNDERTAKER Hof Funeral Dir

ADDRESS 112 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

May Hartz.

D 89504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/24 D 89504

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 1611 E. Pratt St St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... May Hartz

(a) Residence No.. 1611 E. Pratt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fmale

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Sept 1 1878

7-AGE, 45 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) Common Pleas Ct.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Myers Hartz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Rebecca Adler

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14- (Informant) Godfrey Cotton

(Address) 1210 Dorithan

AUG 17 1924 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 15 24

17- I HEREBY CERTIFY, That I attended deceased from June 1, 19 24, to August 15, 19 24

that I last saw h. alive on August 15, 19 24

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Jos. L. Wehrbein M. D.

August 15 1924 (Address) 16 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Balto Hebrew Cem	Aug 19 1924
20-UNDERTAKER.	ADDRESS
Jahrens Co	1111 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 16

D 89505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 11 WARD)

2-FULL NAME Lida Anita Jackson.

(a) RESIDENCE NO. Kenwood Ave Catonsville MD WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. General Hospital

PARENTS

10 NAME OF FATHER Ralph M. Jackson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cromwell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mary E. Jackson (mother) (Address) Kenwood Ave Catonsville Md

Filed AUG 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 , 1924, to Aug 16 , 1924, that I last saw her alive on Aug 16 , 1924, and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

Chronic Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Thos A Tompkins M.D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Aug 18 1924

20 UNDERTAKER Harry H Nitzka ADDRESS 1531 Woodland Pl

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2/ D 89506

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4111 Massachusetts Ave ST., 20 WARD)

2-FULL NAME Carl S. Morgan

(a) RESIDENCE NO. 4111 Massachusetts Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) March 13-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 054

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Herbert Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A. Hapel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Herbert W Morgan
(Address) 4111 Massachusetts Ave

15 Filed AUG 17 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to August 14, 1924.
that I last saw h.. alive on Aug 13, 1924.
and that death occurred, on the date stated above, at 750 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Tuberculosis

(duration) yrs. 15 mos. ... ds.

CONTRIBUTORY (Secondary) Septic, Endocarditis

(duration) yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Theo Koeppen M. D.
(Address) Aug 15/24 1900 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 15 1924
20 UNDERTAKER	ADDRESS
Harry H. Nitzke	1538 W Fayette St

Cor.—1-12-23—M&T—100 Bka.

D 89507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at 188-603 D 89507

CITY OF BALTIMORE: (No. Day Pier Hosp ST., N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Authey

(a) RESIDENCE No. 515 S 12 St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 - 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	—	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert E Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Hoffert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert E Arthur
(Address) 515 S 12 St

15 Filed AUG 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Auto Accident
Instantaneous
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Hutton, M. D.
(Coroner.)
Aug 16, 1924 (Address) Govans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem — DATE OF BURIAL Aug 19 1924

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89508

CERTIFICATE OF DEATH.

D 89508

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3242 Frederick Av St., 20 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Bagnol

(a) Residence No. 3242 Frederick Av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

4-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 12–17, 1921

7-AGE, 3 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry E Bangol

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Bessie L Bazzell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

11- (Informant) Henry Bagnol

(Address) 3242 Frederick Ave

15- AUG 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug-17-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1924 to Aug 17 1924

that I last saw him alive on Aug 16 1924

and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

This patient was seen by Dr Howard Jones who is ret

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 2 mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Bagnol M. D

19 (Address) 904 N Chamberlain

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemty

DATE OF BURIAL. Aug 18 1924

20-UNDERTAKER W M Cook

ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89509

CERTIFICATE OF DEATH.

114 D 89509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 N. Fork St., 8 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Eliz. Price

(a) RESIDENCE NO. 1802 N. Fork St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	~~White~~	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. M. Price

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1897 Guess

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter S. Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Wehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William M. Price
(Address) 1802 N. Fork St.,

15 Filed AUG 18 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) acute Dil. of heart 15 min.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Aug. 16. 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Moravia Cemetery	Aug 18 1924
20 UNDERTAKER William Cook	ADDRESS 502 E Fort Ave

Cor.—1-12-23—M&T—100 Bks.

D 89510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89510

CERTIFICATE OF DEATH.

15-74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 W North ave ST., 15 WARD)

2-FULL NAME Hulda Scherf

(a) RESIDENCE NO. 2206 W North ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Scherf

6 DATE OF BIRTH (month, day, and year) Aug. 6. 52

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	—	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Natchmichdt

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Harry J Scherf
(Address) 4714 Park Heights

15 Filed AUG 18 1924, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jur- (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Aug 15, 1924 (Address) 28 Redwood Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug 18 1924

20 UNDERTAKER W M Routson — ADDRESS 2238 W North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89511

CERTIFICATE OF DEATH.

+38

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 11 WARD)

2-FULL NAME Peter B. Samois

(a) RESIDENCE No. Westminster, Md ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work clerk
(b) General nature of industry, business, or establishment in which employed (or employer) candy store
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Basil Samois

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Anna Cosmones

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant
(Address) Westminster Md

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hepatic relapse

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

Aug 11, 1924 (Address) 2 So Paca Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Aug 20 1924

20 UNDERTAKER W M Rouzer

ADDRESS 2238 N Booth

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89512

D 89512

CERTIFICATE OF DEATH.

113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1743 Fleet St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude. Niemiera

(a) Residence No. 1743 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) May 2 1924

7-AGE. ..... yrs. 3 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Tadeusz . Niemiera

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER Petronela Gavinos

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mr Tadeusz . Niemiera
(Address) 1743 Fleet Street

15- Filed AUG 18 1924 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 17/1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 24 to ....., 16.. 19 24

that I last saw h.. alive on, ... 19 24

and that death occurred, on the date stated above, at 1210 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. G. Freedman, M. D

8/17, 19 24 (Address) 1918 E. Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL. Aug. 18, 1924

20-UNDERTAKER. John M Weber — ADDRESS 1803 Bank

17

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89513 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 89513

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Ave W of Windsor Mill Road 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F. Piddicord

(a) Residence No. Forrest ave W of Windsor St. Mill Rd Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 8-1870

7-AGE. 54 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert Kuck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Christiana Litchfield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto

14- (Informant) Walter Piddicord

(Address) Forrest ave near Windsor Mill Rd

15- Filed Aug 16 1924 Registrar.

AUG 18 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 13-24

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to Aug 13 1924

that I last saw h~~e~~r alive on Aug 13 1924

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Chronic Mitral Regurgitation

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ~~No~~ Date of

Was there an autopsy? ~~No~~

What test confirmed diagnosis? Clinical

(Signed) A. C. Dennis M. D.

Aug 17 1924 (Address) 4309 Liberty Hgts

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine — DATE OF BURIAL, Aug 18, 1924

20-UNDERTAKER Fredk. A. Cole — ADDRESS 1411 Hollins St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89514

CERTIFICATE OF DEATH.

D 89514

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2825 Guilford ave ST.; 17 WARD)

REGISTERED NO. C 47

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Reena

(Residence in Baltimore: No. 2825 Guilford ave. St.; 16 yrs., mos. ds.)

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct 28 (Month) 11 (Day) 1855 ~~1924~~ (Year)

7-AGE, 68 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Ford

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER dontlinon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mabry B Bell

(Address) 2825 N. Guilford ave

15-

Filed AUG 18 1924 191.. C G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 16 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1924, to Aug 16 1924, that I saw her alive on Aug 16 1924, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) don't know yrs. mos. ds.

(Signed) Percy Kemp M. D.

Aug 17., 1924 (Address) 2507 N. Calvert St.,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Aug 18.., 1924

20-UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89515

CERTIFICATE OF DEATH.

43v

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3401 Callaway St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis E. Creamer

(a) Residence No. 3401 Callaway St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 4 mos. 2 ds. | How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edna B. Creamer

6-DATE OF BIRTH (month, day and year) Apr. 14, 1876

7-AGE. 48 yrs. 4 mos. 2 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Natl Union Bank

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Anthony Creamer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Dersch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Mrs Edna B. Creamer

(Address) 3401 Callaway Ave

15- AUG 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Aug 16 1924

that I last saw him alive on Aug 16 1924

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Face

5

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage Immediate

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Radium Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Henry J. Haberl M. D

Aug 16 1924 (Address) 225 N. Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. | DATE OF BURIAL. Aug 18 1924

20-UNDERTAKER Wm J. Eichner Sons | ADDRESS Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. MARGIN RESERVED FOR BINDING. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89516

CERTIFICATE OF DEATH.

D 89516

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Leed ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Baskerville

(a) RESIDENCE. NO. 3142 Leed ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Baskerville nee Gaither

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	8.	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alice V. Baskerville

(Address) 3142 Leeds Street

15 Filed 19 Registrar

AUG 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 — 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6th, 1924, to Aug 16, 1924, that I last saw h.. alive on Aug 16, 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Organic Cardiac Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Examination

(Signed) Emmett Forge, M. D.

, 19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mommy Har Den	8/19/24
20 UNDERTAKER	ADDRESS 916
Dud Carbin	Ca on

Spec–12-23-21–E.B.R.S.–400 Bks.

D 89517 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 N Stricker St. 16 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Johnson

(a) Residence No. 1109 N Stricker St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 27. 1922

7-AGE. 1 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country).

PARENTS.

10-NAME OF FATHER, James Johnson

11-BIRTHPLACE OF FATHER (city or town) S.C. (State or Country).

12-MAIDEN NAME OF MOTHER, Stella Ennis

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country).

14- (Informant) Stella Johnson

(Address) 1109 Stricker St

15- Filed AUG 18 1924 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1924 to Aug 15 1924

that I last saw h.. alive on Aug 14 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Not Date of.....

Was there an autopsy? no

What test confirmed diagnosis? None except physical signs

(Signed) Harry D. McCarty, M. D.

, 19 (Address) 1139 N Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 8/18–24, 19....

20-UNDERTAKER. Denis Taylor

ADDRESS 116 N Eu

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

D 89518 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89518

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at 12 9

CITY OF BALTIMORE: (No. Bay View Hospital ST., ... WARD)

2-FULL NAME John Cornelius

(a) RESIDENCE NO. 1117 Thompson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Cornelius

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Grocer
(c) Name of employer Emily Schriever

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Cornelius

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Jane Cornelius
(Address) 1117 Thomas

15 Filed AUG 18 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Fatty Infiltration

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D.
(Coroner)
Aug 16, 1924 (Address) 700 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 18 1924

20 UNDERTAKER Ida. Snowden. ADDRESS 1725 Oakland

CAUSE OF DEATH in plain terms, so that it may be proper... TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89519

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 W. Lombard ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie L. Whalen

(a) RESIDENCE NO. 1141 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James C. Whalen

6 DATE OF BIRTH (month, day, and year) 7/28/66

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jno Mitchell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Nellie Whalen
(Address) 1141 W Lombard St

15 Filed AUG 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/24 19

17

I HEREBY CERTIFY, That I attended deceased from 5/20/, 1923, to 5/17/24, 19,

that I last saw h.. alive on 5/16/24, 19,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg.

Chr. Diff. Neph.

None

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Spinal Arthritis (Osteo)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leonard Tarr, M. D.

5/18/, 1924 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 20 1924
20 UNDERTAKER	ADDRESS
Wm J. Fields	1200 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

D 89520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89520

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2541 E. Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Tagg Jr.

(a) RESIDENCE NO. 2541 E. Monument ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. A. Tagg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lena Grasser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Lena Tagg

(Address) 2541 E. Monument.

15 Filed AUG 19 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17

I HEREBY CERTIFY, That I attended deceased from July 26th '11 1924, to Aug 17th '11 1924.

that I last saw him alive on Aug 25th, 1924,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis Acute Parenchymatous

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. King Joslin, M. D.

1924 (Address) 1017 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 19 1924
UNDERTAKER	ADDRESS
Jos. J. Kerr	1806 N. Luzerne

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Alethia Potter)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89521

CERTIFICATE OF DEATH.

1299 D 89521

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N Central Ave ST., 5 WARD)

2-FULL NAME Alethia Potter

(a) RESIDENCE NO. 627 N Central Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Brown	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William T Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant William L. Potter

(Address) 627 N. Central Ave

15 AUG 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to ....., 19....., that I last saw h[illegible] alive on Aug 15, 1924, and that death occurred, on the date stated above, at 2.25 P m.

The CAUSE OF DEATH* was as follows:

Interstitial hepatitis

(duration) 27 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. Hrs. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical & Microscopic

(Signed) ..... M. D.

, 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	8/18/1924
20 UNDERTAKER Byron Wright	ADDRESS 1218 E Eldeney

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89522

CERTIFICATE OF DEATH.

24 58 1001 D 89522

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 Johnson St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Matilda Carter.....

(a) Residence No. 225 E. Heath St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Carter

6-DATE OF BIRTH (month, day and year) Dec. 9 1868

7-AGE.	If LESS than 1 day,
55 yrs. 8 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

037

9-BIRTHPLACE (city or town).....Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Jacob Heerd

11-BIRTHPLACE OF FATHER (city or town)...Germany
(State or Country).

12-MAIDEN NAME OF MOTHER, Mary Krebs

13-BIRTHPLACE OF MOTHER (city or town).Germany
(State or Country).

14-

(Informant)...John J. Carter

(Address).....225 E. Heath St.

15- AUG 18 1924

.....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 16, 1924.

17- I HEREBY CERTIFY, That I attended deceased from May 7, 1924 to Aug. 16, 1924, that I last saw her alive on Aug. 16, 1924, and that death occurred, on the date stated above, at 9 Am. m.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anaemia

.....(Duration).....yrs. 4 mos.....ds.

CONTRIBUTORY - - - - - - - -
(Secondary)

.....(Duration)... - yrs. - mos. - ds.

18-Where was disease contracted if not at place of death? 225 E. Heath St.

Did an operation precede death? no Date of ----

Was there an autopsy? no

What test confirmed diagnosis? Blood Chemistry

(Signed) Harry Kleibel M. D

8/17/1924 (Address) 1224 Hanover Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon PK	8/19, 1924
20-UNDERTAKER.	ADDRESS
J. Fred McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89523

CERTIFICATE OF DEATH.

113 D 89523

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 S. Kenwood Ave. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozalia Paszkiewicz

(a) Residence No. 916 S. Kenwood Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 6 1918

7-AGE. ... yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md.

PARENTS:
10-NAME OF FATHER, Peter Paszkiewicz
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland
12-MAIDEN NAME OF MOTHER, Josefa Kotkowska
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Conn.

14-
(Informant) Peter Paszkiewicz
(Address) 916 S. Kenwood Ave

15-
Filed AUG 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 16, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1924 to Aug. 16, 1924, that I last saw her alive on Aug. 16, 1924 and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Circulatory Insufficiency

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? P.S.&S.

8/18, 1924 (Signed) John J. Krager M. D.
(Address) 26 S. Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus	Aug 19, 1924

20-UNDERTAKER.	ADDRESS
S. J. Falkowski	1000 S Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89524

CERTIFICATE OF DEATH.

10 1001 D 89524

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Lessier ST., 17 WARD)

2-FULL NAME. Wm Brown

(a) RESIDENCE NO. 804 Lessier ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elkridge City Md

12 MAIDEN NAME OF MOTHER Ida Ridout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md

14 Informant ..... Newton Brown
(Address) 746 Penna Ave

15 Filed AUG 18 1924 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 14th 1924 to Aug 15th 1924.

that I last saw him alive on Aug 15th 1924,

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

8/15, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 SIGNATURE AND ADDRESS OF BURIAL, CREMATION OR REMOVAL PERMIT ..... DATE OF BURIAL Aug 18 1924

20 UNDERTAKER Samuel F Handley ADDRESS 1775 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89525

CERTIFICATE OF DEATH.

5 74

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 207 East St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Nelson A. Eady

(a) Residence No. 207 East St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.)
Male	colored	widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1850

7-AGE.	If LESS than 1 day.
74 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ~~none~~
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.
10-NAME OF FATHER, unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md
12-MAIDEN NAME OF MOTHER, unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Clarence Freeman
(Address) 120 Argyle St

15- Filed AUG 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 14-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1924 to Aug 13 1924
that I last saw h. alive on Aug 13 1924
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:

apoplexy

4 days (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) J. Edward Fisher, M. D.
8-14 1924 (Address) 1617 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
National Cem.	Aug 17
20-UNDERTAKER Samuel F. Hensley	ADDRESS 1 E Biddle

D 89526

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 89526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2044 E. Preston ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Elizabeth Hardman

(a) RESIDENCE. No. 2044 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2nd 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical Work

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Casualty

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jay W. Hardman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Florence Elgrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jay W. Hardman

(Address) 2044 E. Preston St.

15 FILED AUG 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1923, to Aug 16 1924, that I last saw h e alive on Aug 15, 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

1 Streptococcus Viridans

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

8/16. 19 (Address) 1800 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Aug. 18 1924
20 UNDERTAKER	ADDRESS
William W. Shriver	1018 Edmonds Av.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 89527 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89527

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Milton Siegel

(a) RESIDENCE NO. 214 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Mr. Siegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Finkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Son

15 Filed AUG 18 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 1924, to Aug 17, 1924, that I last saw him alive on Aug. 17th, 1924, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Sondheimer, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Sinai Rosendale DATE OF BURIAL 8/18 1924

20 UNDERTAKER Jack Levis ADDRESS 1439 E Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE OR OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89528 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89528

CERTIFICATE OF DEATH.

9 129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 E 35 th St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert H Lankford.

(a) Residence No. 504 E 35 th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed or ~~Divorced~~, (~~Write~~ the word.) Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND ~~of (or) WIFE of~~ Helena Lankford

6-DATE OF BIRTH (month, day and year) July 13 1849

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Jeweler 38

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Wm Lankford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Grace H. Jeorges

(Address) 504 E 35th st.

15- AUG 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 th, 1924 to Aug 15, 1924

that I last saw h. ~~in~~ alive on August 15 th, 1924

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Infection (Carbuncle)

Arteriosclerosis, chronic

interstitial nephritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Heart failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Thos A Bullock M. D.

8/16, 1924 (Address) 1623 E Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Dallo Cemetery	aug 18, 1924

20-UNDERTAKER	ADDRESS
Robt J Turner Inc	1442 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 405 S. Regester St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Angelo

(a) Residence No. 405 S. Regester St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mch 2nd 1924

7-AGE. ... yrs. 5 mos. 15 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Domonic Angelo

11-BIRTHPLACE OF FATHER (city or town) Italy (State or Country),

12-MAIDEN NAME OF MOTHER, Ella Vain

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Ella Angelo (mother) (Address) 405 S. Regester St.

15- AUG 18 1924 19... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 17th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 12, 1924 to Aug 17, 1924

that I last saw him alive on Aug 17, 1924

and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

Acute Enteritis

(Duration) ... yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Manuel A. Tucker, M. D

, 19... (Address) 332 S Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cem.	Aug 19, 1924
20-UNDERTAKER,	ADDRESS
Lilly & Zeiler	1103 So. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89530

CERTIFICATE OF DEATH.

74-001

D 89530

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Arnold St. ST., 14 WARD)

2-FULL NAME Sarah Jones

(a) RESIDENCE NO. 1506 Arnold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levi Jones

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE: 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Evans

(Address) 106 Biddle St

15 AUG 18 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-11-24, 19..., to 8-16-24, 19..., that I last saw h... alive on 8-16-24, 19...

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) debility, Cat pemitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

8/16/24 (Address) F. M. Caddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 8/20/24

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 David Hillave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89531 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89531

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH M. E. H. Bay View Hospital Registered No.....

City of BALTIMORE: (No. Bobo St., ...N... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Delia Godwin

(a) Residence No. 312 E. 12th St. Highlandtown St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 29 1871.

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ga.

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ga.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ga.

14- (Informant) Hospital Records

(Address)

15- Filed AUG 18 1924 192 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1924 to Aug 15 1924, that I last saw h[illegible] alive on Aug 15 1924, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Adv. Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. & Lab findings

(Signed) L. H. White M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Leesburg Ga.	Aug 19th 1924
20-UNDERTAKER,	ADDRESS
Leo D. Cook	North Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89532

D 89532

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Municipal TB Hospitals

City of BALTIMORE: (No. Bay View St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Tate

(a) Residence No. 582 Oxford Av. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N Va.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N Va.

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N Va

11- (Informant) Hospital Records

(Address)

15- Filed Robert P. Harrison, Registrar.

AUG 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-17-24

17- I HEREBY CERTIFY, That I attended deceased from May 24 19 24 to Aug. 17 19 24

that I last saw him alive on Aug. 17 19 24

and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Advanced Pulmonary TB.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted ?
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. findings

(Signed) James Thistle M. D.

, 19 (Address) Bay View Hospitals

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Charles Town W Va — DATE OF BURIAL. 8-18, 19 24

20-UNDERTAKER. E & B Harle — ADDRESS 1156 E Mt St

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 89533

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Young

(a) RESIDENCE NO. 306 E. 24th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1842

7 AGE: Years 82; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph M. Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Anne Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Record (Address)

15 Filed AUG 18 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/18/24

17 I HEREBY CERTIFY, That I attended deceased from 7/24/24 19..., to 8/18/24 19..., that I last saw h[illegible] alive on 8/18/24 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. W. Goltry M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Aug 19 24

20 UNDERTAKER: Chas. P. Crane & Son — ADDRESS: 1128 W. Mt. Royal Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 89534

1-PLACE OF DEATH St Vincents Infr Asy.

CITY OF BALTIMORE: (No. 1401 — Division ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Burroughs

(a) RESIDENCE No. 1401 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Butte City

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Bernice Burroughs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant St Vincent Infl Asy (Address) 1401 Division St.

15 Filed . 19 Robert P. Harrison Registrar

Burial Permit Clerk

AUG 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to Aug 17, 1924, that I last saw h[illegible] alive on Aug 17, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

. 19 (Address) 2923 St Paul St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Aug 19 19

20 UNDERTAKER Martin Funeral Home — ADDRESS 1827 N North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89535

CERTIFICATE OF DEATH.

D 89535

83

1-PLACE OF DEATH 1904 W. Pratt St.

CITY OF BALTIMORE: (No. Alfred Wettengel ST., 71 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Wettengel

(a) RESIDENCE NO. 1904 W. Pratt ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 15 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis

6 DATE OF BIRTH (month, day, and year) Jan. 31—1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
56	1868	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lemberg, Galicia (Austria)

PARENTS

10 NAME OF FATHER Alfred Wettengel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs. Francis Wettengel (Address) 1904 W. Pratt St.

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk

AUG 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922 to Aug. 16, 1924, that I last saw him alive on Aug 16, 1924, and that death occurred, on the date stated above, at 8 o'clock P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Encephalitis softening of brain (duration) 2 yrs. 2 mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. F. Scheele, M. D.

, 19 (Address) 1001 Linganith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 19 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	413 N. Eutaw St.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 89536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89536

CERTIFICATE OF DEATH.

5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 Hillman ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Hughes

(a) RESIDENCE NO. 1326 Hillman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? 56 yrs. 10 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Michael J. Hughes

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adelbert Ochs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Klee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret M. Hughes

(Address) 1326 Hillman St

15 Filed AUG 18 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 19, to Aug 17, 1924, that I last saw her alive on Aug 16, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Urine .....

(Signed) Hubert Latrobe, M. D.

Aug 18, 1924 1216 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Aug 20 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89537 — 17347

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 89537

CERTIFICATE OF DEATH.

118-008

1-PLACE OF DEATH Johns Hopkins Hospl

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

2-FULL NAME Dr. John Geraghty

(a) RESIDENCE No. Charles St Ave ST. White Field Road WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Sanner

6 DATE OF BIRTH (month, day, and year) July 24 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Minn St Paul

PARENTS

10 NAME OF FATHER Charles Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country) ########## Minn.

12 MAIDEN NAME OF MOTHER Bridget Corcoran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ########## Ireland

14 Informant Regards

(Address) Johns Hopkins Hospital

15 Filed AUG 18 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 19 24, to Aug 17, 19 24,

that I last saw him alive on Aug 17, 19 24

and that death occurred, on the date stated above, at 3 ~~16~~ a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Sigmoid Diverticulum

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Aug 11 24

Was there an autopsy? Yes Aug 16 24

What test confirmed diagnosis? Operation

(Signed) J. L. Reichert M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Vault — DATE OF BURIAL 8/19 19 24

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS 805 N. Calvert St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89538 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89538

CERTIFICATE OF DEATH. 106-001

1-PLACE OF DEATH Bay View Hospital 76 Registered No.....

City of BALTIMORE: (No.) Bay View Asylum St., ... Ward)

2-FULL NAME Samuel McGinnis Jr. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1840

7-AGE, 84 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER Samuel McGinnis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York.

12-MAIDEN NAME OF MOTHER, ~~MOTHER~~ Honnicer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14-(Informant) Hospital Records.
(Address) Bay View Hospital Baltimore

15-Filed AUG 18 1924 Robert F. Harrison, Registrar.

AUG 18 1924 Burial Permit (Clerk.) 1695

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8/15/24.

17- I HEREBY CERTIFY, That I attended deceased from 8/6/24 to 8/15/24, that I last saw him alive on August 15 19 24 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH was as follows:

Ischio Rectal Abscess.
Thrombotic & ulcerated
hemorrhoides.
(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Terminal Broncho.
Pneumonia (Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 8/14/24.

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical & Laboratory

(Signed) Wm. A. Stucky M. D.

(Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner Health. ADDRESS AUG 18 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

16. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's statement as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-01 D 89539

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hosp-

CITY OF BALTIMORE: (No. Lombard & Greene ST., 22 WARD)

2-FULL NAME Lee Harris -

(a) RESIDENCE NO. 100 Block Lee ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Johnston.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant
(Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

AUG 18 1924

Burial 16,36 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 1924, to 8/14, 1924,

that I last saw him alive on 8/14, 1924,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No - Date of

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

AUG 18 192

Cor.—1-12-23—M&T—100 Blks.

D 39540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39540

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 N. Carrick ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Young

(a) RESIDENCE NO. 1131 N. Carrick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thos. Gassoway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ethel Young
(Address) 1131 N. Carrick St.

15 Filed AUG 18 1924, 192 Robert F. Carrison, Registrar

Number 16598

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) none known

(duration) ... yrs. ... mos. ... ds.

(Signed) D. J. Hennessy, M. D.
(Coroner.)

Aug. 16, 1924 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL AUG 18 1924

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89541

CERTIFICATE OF DEATH.

C D 89541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W Mulberry ST., 4 WARD)

REGISTERED NO. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johns Johns'

(a) RESIDENCE No. 505 W. Mulberry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 45 or 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Nurse
(Address)

15 Filed AUG 18 1924, 192 Robert P. Harrison, Registrar 1699

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 16 Aug 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~inquest~~ au~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation Illuminating Gas

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ... yrs. ... mos ... ds.

(Signed) H. R. Gruner, M. D.
(Coroner.)

8-18, 1924 (Address) 1171 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND. Commissioner of Health. AUG 18 1924

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89542

CERTIFICATE OF DEATH.

1 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp 16 St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Everett

(a) RESIDENCE NO. Joppa Rd, Towson Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15th 1924

7 AGE — Years — Months — Days — If LESS than 1 day, / hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Clarence Everett

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Rose Deleon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant
(Address)

15 AUG 18 1924 19 Robert E. Harrison, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to Aug 15, 1924, that I last saw her alive on Aug 15, 1924, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis.

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Manninger, M. D.

Aug 15 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

AUG 16 1924

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 89543

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-00

D 89543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alice Maine Hospital ST. WARD)

2-FULL NAME 410-N-Stricker St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/15/24

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) 410-N. Stricker St
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Stanley

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Ramm

13 BIRTHPLACE OF MOTHER (city or town) Rockbridge Co. Va.
(State or country)

14 Informant Chloe Ramm
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 18 1924 19 1700 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/24

17 I HEREBY CERTIFY, That I attended deceased from 8/15 19 24 to 8/17 19 24
that I last saw her alive on 8/16 19 24
and that death occurred, on the date stated above, at 2:20 p m.
The CAUSE OF DEATH* was as follows:

Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. L. Gardner M. D.

8/17 19 24 (Address) 8 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: AUG 18 19 24

20 UNDERTAKER — ADDRESS

(Robert B.) Morrison
Commissioner Health.

Chief Permit Clerk.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Rks.

D 89544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 89544

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST. W WARD)

2-FULL NAME Anna Schaub

(a) RESIDENCE No. 51 S Eleventh St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Leo Schaub

6 DATE OF BIRTH (month, day, and year) Dec 27 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER John G. Markert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Francis Leo Schaub (Address) 51 S Eleventh St

AUG 18 1924

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1924, to Aug 16, 1924, that I last saw her alive on Aug 16, 1924, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis, Salpingitis, Pelvic abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Aug 15/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. B. Gybert, M. D.

. 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 19 1924
20 UNDERTAKER	ADDRESS
Wendell Bryfogle & Son	373 Mn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89545

HEALTH DEPARTMENT—CITY OF BALTIMORE

DV89545

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 211 Roland Ave. or Roland Park) Ward 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Aloysius Frederick

(a) Residence No. 211 (Usual place of abode) St., Roland Ave Ward Residents

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? 82 yrs. 8 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Frederick

6-DATE OF BIRTH (month, day and year) Dec 16-1842

7-AGE. 82 yrs. 8 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country).....

PARENTS.

10-NAME OF FATHER, John M. Frederick

11-BIRTHPLACE OF FATHER (city or town)..... Germany

(State or Country).....

12-MAIDEN NAME OF MOTHER, Margaret Hildt

13-BIRTHPLACE OF MOTHER (city or town)..... Germany

(State or Country).....

14-

(Informant) Miss Katharine Frederick

(Address) 211 Roland Ave

15-

Filed ..... 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 17, 24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1924 to Aug. 17, 1924

that I last saw him alive on Aug. 17, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis about 5 yrs.

Myocarditis (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Theo. H. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug. 19, 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. STEWART, Supervisor) — ADDRESS 108 W. [illegible]

AUG 18 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89546

D 89546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Poplar Grove St. WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Susanna Bokee

(a) RESIDENCE. NO. 2006 Poplar Grove ST., 16 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? 65 yrs. 5 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto-Md
(State or country)

PARENTS

10 NAME OF FATHER William F. Bokee

11 BIRTHPLACE OF FATHER (city or town) Balto-Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A McElhaine

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Mr Wm F. Bokee
Address 2006 Poplar Grove St

15 Filed AUG 18 1924, 19 .

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1924, to Aug 17, 1924, that I last saw h[illegible] alive on Aug 17, 1924, and that death occurred, on the date stated above, at 8 o'clock P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Randall Mowen, M. D.

1924 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug-20 1924
20 UNDERTAKER STEWART & MOWEN COMPANY	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89547

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Nellie Rheins

Presbyterian Home of Maryland

(a) RESIDENCE NO. 822 Carrollton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah G. Rheins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Presbyterian Home Records

(Address)

15 Filed AUG 18 1924, 19 Robert P. Harrison, Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1924, to Aug 17, 1924, that I last saw her alive on Aug 17, 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.
Operation Hysterectomy 3 yrs ago.
Recurrence of Carcinoma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction caused by recurrence in pelvis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? 3 yrs ago Date of 1921

Was there an autopsy? No

What test confirmed diagnosis? none.

(Signed) Raymond I. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 19 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Wright
3939 Greenmount

D 89548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89548

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE. (No. 116 East Preston St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca V. Vansant

(a) Residence No. 116 East Preston St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John M Vansant

6-DATE OF BIRTH (month, day and year) Oct- 4, 1848

7-AGE 75 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Kent Co Md

PARENTS.

10-NAME OF FATHER John M. Bartlett

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Sarah Turner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Mary B. Didier

(Address) 116 E Preston

15- Filed AUG 18 1924 19?

Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 17 1924

17- I HEREBY CERTIFY, That I attended deceased from August 11 1924 to August 17 1924

that I last saw h[illegible] alive on August 17 1924,

and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with hypertension

(Duration) unknown.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted? If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood pressure, Paralysis of respiratory muscles

(Signed) Harold E. Wright, M. D

8/18, 1924 (Address) 3939 Greenmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 19, 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

1—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Hilda Ashton

D 89549

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89549

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Ashton

(a) RESIDENCE No. 242 No Caton St ST. 1907 WARD Patt Park Co.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Ashton

6 DATE OF BIRTH (month, day, and year) May 15 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Wuggral-

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER August Kunz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katie Kasl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Pat Patterson

15 Filed ..... 192 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

AUG 18 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Incomplete abortion self induced (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy (Coroner.), M. D.

Aug 18, 1924 (Address) 220 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug. 19 1924

20 UNDERTAKER Wm Cook & Son Fulton ADDRESS

Spec—12-23-21—E.B.P.S.—400 Bks.

D 89550

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-006 89550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Montana Ave St., Belair Rd Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Eiblar

(a) Residence No. 7 Montana Ave St., Belair Rd Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) Aug 18/24

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frank Eiblar

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Helen Keller

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto

14- (Informant) Frank Eiblar

(Address) 7 Montana Ave

15-

Filed ..... 19?.....

AUG 19 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 18/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 19 24 to Aug 18 19 24

that I last saw h alive on Aug 18 2 p.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Endometritis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth (Cesarean)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) 8-18-24 T. Turner Hoff M. D

(Address) 700 N Patt Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (I) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL. Aug 19, 1924

20-UNDERTAKER Frank Eiblar Son — ADDRESS 1900 Eastland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89551

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-006 89551

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 N. Lakewood Ave ST., 7 WARD)

2-FULL NAME Edward Taydor Anaron

(a) RESIDENCE NO. 540 N. Lakewood Ave. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth K. Anaron

6 DATE OF BIRTH (month, day, and year) Aug. 2nd. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	64	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Special officer 039

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Alex. Brown & Son.

9 BIRTHPLACE (city or town) Westmoreland Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Thomas Aharon

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Branson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant Elizabeth K. Aharon
(Address) 540 N Lakewood Ave

15 Filed AUG 19 1924, 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/24 19

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1924, to aug 17th 1924, that I last saw him alive on aug 17th, 1924, and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 2 mos 17 ds.

CONTRIBUTORY (Secondary) Cerebral Haemmorhage (duration) yrs. mos. 10 hrs.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) Robert S. Kirk, M. D.

8/18, 1924 (Address) 3126 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL 11/20/24

20 UNDERTAKER: H. E. Hughes, 424 N. Broadway — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

89552 HEALTH DEPARTMENT—CITY OF BALTIMORE 89552

CERTIFICATE OF DEATH.

14-001

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Homewood Apts. St., Charles 31. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis H. Gettier

(a) Residence No. Homewood Chas. 31st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Gettier

6-DATE OF BIRTH (month, day and year) July 21. 1856

7-AGE. 68 yrs. = mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired 15

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Merchant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Gettier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Barbara Rose

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Margaret M. Gettier

(Address) Homewood Apts.

15- AUG 19 1924 G.G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1/24 19 to Aug 15 19 24

that I last saw h[illegible] alive on August 15 19 24

and that death occurred, on the date stated above, at 9.06 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Gray M. D.

8/17 1924 (Address) 622 W. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Aug. 19, 1924

20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead

REGISTERED NO. 7400

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose B Davis

(a) RESIDENCE NO. 112 S Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced (or) WIFE of John Davis

6 DATE OF BIRTH (month, day, and year) Jan 9-73

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Edward Pipes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Bedford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Davis
(Address) 112 S. Durham

15 Filed AUG 19 1924 GLS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy Various

Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James McCulloch, M. D.
(Coroner)

Aug 16, 1924 (Address) Fort Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem — DATE OF BURIAL Aug 19 1924

20 UNDERTAKER Wm H. Chase & Son — ADDRESS 1450 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89554

CERTIFICATE OF DEATH.

90 D 89554

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 W. Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME La Motte H. Martyne

(a) RESIDENCE. No. 1042 W Fayette ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary L Martyne

6 DATE OF BIRTH (month, day, and year) March 22. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72.	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman at 073

(b) General nature of industry, business, or establishment in which employed (or employer) Camden Station

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER La Motte H. Martyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Mary Louise McCoy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Hannie M Bond
(Address) 1042 W Fayette St

15 Filed AUG 19 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1924. to Aug 17 1924.
that I last saw him alive on Aug 17 1924.
and that death occurred, on the date stated above, at 10.30 A. m.
The CAUSE OF DEATH* was as follows:

acute
Myocardial Degeneration

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Mitchell, M. D.

Aug 18 1924 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 20 24

20 UNDERTAKER	ADDRESS
George J Smith	1537 Hollins St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89555

D 89555

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) University Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Carr-

(a) RESIDENCE No 905 N Patterson Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Carr

6 DATE OF BIRTH (month, day, and year) May 21, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John F. Richardson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant James Carr
(Address) 905 Patterson Park

15 Filed AUG 19 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Had done chiks probably

Fracture of Femur (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Ensor, M. D.
(Coroner)

8-18, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 21, 1924
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 V D 89556

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Foot of Kenwood Ave

CITY OF BALTIMORE: (No. Spedden's Wharf ST., WARD)

2-FULL NAME Frank S. Mauler

(a) RESIDENCE NO. 333 S. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mauler

6 DATE OF BIRTH (month, day, and year) July 27, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	0	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Tin decorating Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George E. Mauler

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elizabeth Mauler
(Address) 333 S. Robinson St.

15 Filed AUG 19 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning
fell from wharf

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Kemler, M. D.
(Coroner.)

Aug 19, 1924 (Address) Fort Clark

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Aug 19 1924

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1710 Fleet St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89557 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89557

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 Alice Ann ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kues Jr.

(a) RESIDENCE NO 1911 Alice Ann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Kues

6 DATE OF BIRTH (month, day, and year) Sept 27 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Horse Dealer
(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Kues

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Mahr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14
Informant George W. Kues
(Address) 1911 Wisconsin St.

15 Filed AUG 19 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Cause death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Gaulon, M. D.
(Coroner.)
Aug 19, 1924 (Address) Fort Chart

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Aug 20 1924
20 UNDERTAKER	ADDRESS
H. Vander & Sons	1710 Fleet St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89558 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89558

16-36 Dist. of Pulaski

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 631 Walpert Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. E. Forest

(a) Residence No. 631 Walpert Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Mar'd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 21 - 1923

7-AGE. 1 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Elias Forest

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER, Rosalia Moores

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14- (Informant) Elias Forest

(Address) 631 Walpert Ave

15- Filed AUG 19 1924 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15 1924

17- I HEREBY CERTIFY, That I attended deceased from 8/10, 1924 to 8/15, 1924

that I last saw h. alive on 8/17, 1924

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Exhaustion

(Duration) yrs. mos. 8 ds

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) Jay D Pentecost M. D

8/19/24 (Address) 1623 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug 20, 1924

20-UNDERTAKER, Edw. Lovett & Bro. ADDRESS 1623 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

D 89559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89559

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., WARD)

2-FULL NAME Louis Deitz

(a) RESIDENCE NO. 130 North Front st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Victor Deitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jos. Deitz Wendell N. C.

15 Filed AUG 19 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1924, to Aug 19, 1924, that I last saw h.. alive on Aug 19, 1924, and that death occurred, on the date stated above, at 130 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum and Pons.

Pulmonary Edema.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Lindenmeyer M. D.

8/19 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

DATE OF BURIAL 8/19, 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 112 E Balto St

WARNING—THIS SPACE RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 19 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

Walton

D 89560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89560

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Sisters of Bon Pour St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Walter Walton

(a) Residence No. Preston Valley Ho St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed, or Divorced~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Martin

6-DATE OF BIRTH (month, day and year) 1849

7-AGE, ...75....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Alex Walton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant)..... Sister Florence

(Address)..... Preston Valley

15- Filed ..... 19..... Registrar.

Robert F. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 18/24

17- I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to ....., 19....., that I last saw h.. alive on Aug 18, 1924 and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Coma 2 days

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F A Warman, M. D.

Aug 18, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Aug 19, 1924

20-UNDERTAKER, H. C. Wiedefeld — ADDRESS 914 Greenmount Ave

AUG 19 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89561

A 38561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital 16-002

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No..... ST., 7 WARD)

2-FULL NAME Louis Irvin Sentz

(a) RESIDENCE No. 114 S. Duncan St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov 29, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —"—
(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gustan-Sentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Espey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed ....., 19..... Robert P. Harrison, Registrar
Burial Permit Clerk.

AUG 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1924, to August 12, 1924, that I last saw him alive on August 12, 1924, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery
(Organism unidentified)
(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. H. Wesch, M. D.

, 19 (Address) Johns Hopkins Hop.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL aug 20 1924

20 UNDERTAKER John F. Moran — ADDRESS 3000 East Balto St

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89562

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 89562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 N Pappleton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Anderson

(a) RESIDENCE NO. 237 N Pappleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Sngle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bath City
(State or country)

PARENTS

10 NAME OF FATHER James Anderson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Cassie Simmons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Cassie Simmons
(Address) 132 Eagle Ave

15 Filed AUG 9 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Head & Food

(duration) yrs. 1 mos. ds.

(Signed) H H Jones M. D.
(Coroner.)

8-18, 1924 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 18 1924
20 UNDERTAKER Samuel J Kennedy	ADDRESS 1718 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 191924

Spec.—1-10-21—M&T—1500 Blks.

D 89563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89563

1-PLACE OF DEATH Church Home + Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Edward W. Wroth

(a) RESIDENCE NO. Darlington Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret G. Price

6 DATE OF BIRTH (month, day, and year) Oct 8, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas G. Wroth M.D.

11 BIRTHPLACE OF FATHER (city or town) Kent Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wroth

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.

(State or country) Maryland

14 Informant Rev E. Pinkney Wroth

(Address) Laurel, Md.

15 Filed ....., 19 Robert F. Harrison, Registrar

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1924

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1924, to August 18, 1924, that I last saw him alive on August 18, 1924 and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

chronic nephritis (uremia)

myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Clayton Carothers, M. D.

, 19 (Address) Church Home Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington, Md.

DATE OF BURIAL 8/20 1924

20 UNDERTAKER Henry W. Mears & Son 805 N. Calvert St.

ADDRESS

S. R. MEARS - ESCORT

Spec.—1-10-21—M&T—1500 Blks.

D. 89564 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 89564

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 North Durham ST., 6 WARD)

2-FULL NAME Thomas J. Thompson

(a) RESIDENCE NO. 432 N. Durham St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Irene J. Thompson

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Blacksville S.C.

PARENTS

10 NAME OF FATHER Elias Thompson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Emeline Hilley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Irene J. Thompson (Address) 432 N. Durham St.

AUG 19 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to August, 1924, that I last saw him alive on August 14, 1924, and that death occurred, on the date stated above, at 12. p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of frontal sinuses with terminal meningitis.

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Microscopic exam. of tissue

(Signed) C. A. Heathy M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Georgetown S.C.	Aug 21 '24
20 UNDERTAKER Chas. F. Johnson & Co.	ADDRESS N. Carolina St.

MARGIN RESERVED FOR BINDING

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 89565 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 386 E 31 St., 17 Ward)

Registered No. C. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Egbert P. Maynard

(Residence in Baltimore. No. 386 E 31 St; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

6-DATE OF BIRTH. July 14 1865 (Month) (Day) (Year)

7-AGE. 59 yrs. 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Pattern
(b) General nature of indnstry, business, or establishment in which employed (or employer). maker

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. George W Maynard

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Josephine Crawford

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomazin Maynard

(Address) 386 E 31 St

15- Aug 19 1924 Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 18 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John P. Morrison M. D. (Coroner.)

Aug 19 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem DATE OF BURIAL. Aug 20 1924

20-UNDERTAKER. CHENOWETH & SON ADDRESS 2617 CHESTNUT AVE

AUG 19 1924

CAUTION—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89566

CERTIFICATE OF DEATH.

178 D 89566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Berwick Ave. E. of Glenmore St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Keister (KEISTER)

(a) RESIDENCE. No. Berwick Ave E. of Glenmore St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche J. Keister

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) (House)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William H. Keister

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Blanche J. Keister

(Address) Berwick and Glenmore Avenues

15 Filed AUG 19 1924 19 Robert P. Haff Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1 1924 to Aug. 17 1924, that I last saw him alive on Aug 16 1924, and that death occurred, on the date stated above, at 3.25 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Obstruction of Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) Chas. A. Fleischhauer M. D.

8-18-1924 (Address) 1807 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug. 20 1924
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook	1003 N. Eutaw St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89567

CERTIFICATE OF DEATH.

1130 89567

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Rennert Ave St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Fisher

(a) RESIDENCE. NO. 1222 Rennert Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Bernard Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella M. Harley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ella Fisher. (Address) 1222 Rennert Ave

15 Robert P. Harrison Registrar

6 19 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 17, 1924, to Aug 18, 1924, that I last saw h[illegible] alive on Aug 18, 1924, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Faulty Feeding

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. M. Mullo M. D

8/19, 1924 (Address) 1279 Fulliam Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Aug 20 1924
20 UNDERTAKER Wm Cook	ADDRESS 382 E North

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89568

CERTIFICATE OF DEATH.

D 89568

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl. Hos. ST., 23 WARD)

REGISTERED NO. 1179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Trauty

(a) RESIDENCE No. 1642 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. George Trauty

6 DATE OF BIRTH (month, day, and year) April 9, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Alice Trauty

(Address) 1642 S. Charles St.

15 Filed AUG 19 1924, 19 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1924

17

I HEREBY CERTIFY, That I attended deceased from August 14, 1924, to August 19, 1924, that I last saw her alive on August 19, 1924, and that death occurred, on the date stated above, at 5:50 AM

The CAUSE OF DEATH* was as follows:

Cholecystitis — duration 1 year
Chronic appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. 18 hours mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Aug. 18, '24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Trauty, M. D.

. 19 (Address) Md. Gen. Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 8/21 1924

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Fort

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89569

175

1-PLACE OF DEATH

City of BALTIMORE: (No. 942 S. Paca St., H Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stone

(a) Residence No. 942 S Paca St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ Charley M Stone

6-DATE OF BIRTH (month, day and year) July 1870

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14-

(Informant) Charles M. Stone

(Address) 942 S Paca

15-

Filed AUG 19 1924 16- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1924, to Aug 18 1924

that I last saw her alive on Aug 18 1924,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Ptomaine Poison

Acute

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute dilation of Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fanny Boyd M. D

Aug 18 1924 (Address) 602 Wash Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn

DATE OF BURIAL. Aug 20 1924

20-UNDERTAKER. CHENOWETH & SON

ADDRESS 817 CHESTNUT AVE.

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89570

CERTIFICATE OF DEATH.

124

D 89570

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 S. Regester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael . Poturalski

(a) Residence No. 614 S. Regester St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced, HUSBAND of (~~XXXXXX~~) Weronika . Poturalski

6-DATE OF BIRTH (month, day and year): Sep. 29 1886

7-AGE: 37 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): E.J. Cod & Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Wagners Pt. Md.

PARENTS:

10-NAME OF FATHER: George . Poturalski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Antonina Gavinos

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Weronika . Poturalski
(Address): 614 S. Regester Street

15- Filed AUG 20 1924 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 8/19/24

17- I HEREBY CERTIFY, That I attended deceased from July 10 24 to Aug 19 24

that I last saw h~ alive on Aug 19 24

and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Ma Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Roewer M. D

Aug 1924 (Address) 84 N Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Aug. 22 19 24

20-UNDERTAKER: John H Weber ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1525 Fleet St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda . Ustaszewski

(a) Residence No. 1525 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 23 1923

7-AGE, 1 yrs. 5 mos. 25 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph. Ustaszewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Walerja. Jakubiak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mr Joseph. Ustaszewski

(Address) 1525 Fleet Street

15- Filed AUG 20 1924 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) aug 19 1924

17- I HEREBY CERTIFY, That I attended deceased from aug. 17 1924 to aug. 19 1924

that I last saw h[illegible] alive on aug. 18 1924

and that death occurred, on the date stated above, at 830A m.

The CAUSE OF DEATH* was as follows:

Tracheitis

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ... yrs. ... mos. 14 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) John H. Kellogg M. D

(Address) 1709 Eliza[illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cem.	Aug. 20, 1924

20-UNDERTAKER, John A Weber ADDRESS 803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89572

CERTIFICATE OF DEATH.

4/ D 89572

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Harold Lester Gill

(a) RESIDENCE No. Glyndon – Balto Co ST., Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER George Lester Gill

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co – Md
(State or country)

12 MAIDEN NAME OF MOTHER – Jane Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co
(State or country)

14 Informant University Hosp. Records
(Address)

15 AUG 20 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1924, to Aug 19, 1924, that I last saw him alive on Aug 19, 1924 and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

1) Inguinal abscess.

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

Septicemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? —

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carroll Chapel Cemetery — DATE OF BURIAL: Aug 21 1924

20 UNDERTAKER: J. F. Elsie — ADDRESS: Reisterstown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89573 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2500 Roslyn ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Lewis

(a) Residence No. 2500 Roslyn Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cephas M. Lewis

6-DATE OF BIRTH (month, day and year) July 20. 1857

7-AGE. 67 yrs. - mos. 28 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Virginia
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm Lewis

11-BIRTHPLACE OF FATHER (city or town)..... Va
(State or Country),

12-MAIDEN NAME OF MOTHER, Eliz. Jones

13-BIRTHPLACE OF MOTHER (city or town)..... Va
(State or Country),

14- (Informant) Wm G. Lewis

(Address) 2500 Roslyn Ave

15- Filed AUG 20 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 18. 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1924 to Aug 18 1924

that I last saw h.r alive on Aug 18 1924

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Endocarditis

Hypertension

(Duration) 5 yrs. \ mos. \ ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) \ yrs. \ mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Geo H Lyon M. D.

, 19 (Address) 170 W. Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Bundick Va.	Aug 21., 1924
20-UNDERTAKER.	ADDRESS
John D. Mitchell	1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 8 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Christina Morgan

(a) Residence No. 2606 Keyser St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Married~~, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widoned

6-DATE OF BIRTH (month, day and year) June 10/1870

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Henry Morgan

11-BIRTHPLACE OF FATHER (city or town) Rehoboth (State or Country), " Md

12-MAIDEN NAME OF MOTHER, Christina Klein

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), " Md

14- (Informant) Mrs. Virginia Gray

(Address) 2001 Ashton St.

15- Filed AUG 20 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 16th, 1924 to 8/18 1924 that I last saw her alive on Aug 18th 1924 and that death occurred, on the date stated above, at 2.30 P. M. The CAUSE OF DEATH* was as follows:

Auricular fibrillation

Mitral Stenosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. T. Mears, M. D.

, 19 (Address) Hospital Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL, Aug 21, 1924

20-UNDERTAKER, Mrs Mrs N S Finch — ADDRESS 1737 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 89575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89575

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S Gilmore ST.; 19 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Marie Hammer

(Residence in Baltimore: No. 209 S Gilmore St ST.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, July (Month) 7 (Day) 1877 (Year)

7-AGE, 46 yrs. 11 mos. 10 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Baltzer Bach

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. F. Hammer

(Address) 209 S. Gilmor St

15- AUG 20 1924 191.... G G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 17th (Day) 1924 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Aug 24 1924, to Aug 17th 1924, that I saw her alive on Aug 17th 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Lymph's Sarcoma of Breast

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Thalheimer M. D.

Aug 19, 1924 (Address) 1330 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, Aug 20, 1924

20-UNDERTAKER Harry Herwitzke | ADDRESS 581 W Lombard St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

INK—THIS IS A PERMANENT RECORD

Cor.—1-12-23—M&T—100 Bks.

D 89576 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89576

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S. Charles St. ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Owens. (C)

(a) RESIDENCE NO. 614 S. Charles St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 22, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	---	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Grover C. Lee. (C)

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Odessa Owens. (C)

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) North Carolina.

14 Informant Odessa Owens. (C) mother.
(Address) 614 S. Charles St.

15 Filed AUG 20 1924, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Aug. 19, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 20 1924

20 UNDERTAKER John H. Tradum — ADDRESS 1027 Hanover

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—I-12-23—M&T—100 Bks.

Fobes

D 89577 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89577

CERTIFICATE OF DEATH.

18

1-PLACE OF DEATH Foot

CITY OF BALTIMORE: (No. Linden ST., 72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Fobes

(a) RESIDENCE No. Linden Hall Nursery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Scrapman
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Fobes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Gertrude Fisher (Address) 3 E. Chase St

15 Filed AUG 21 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
Struck Walking
Fell Boat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fulton, M. D.
(Coroner.)

Aug 21, 1924 (Address) Fairchild

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 21 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

CAUSE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 89578

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89578

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 805 China St. ST., 22 WARD)

2-FULL NAME Hazel Sample.(C)

(a) RESIDENCE NO. 805 China St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 8, 1901.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Sol Sample.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Whittington.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary Sample.(C) mother.
(Address) 816 China St.

Filed AUG 20 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental scalds about arm & body.
Dysentery.
Acute dilatation of the Heart.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Aug, 19, 1924 (Address) 1217 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death? (c)
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 20 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89579

CERTIFICATE OF DEATH.

1908 D 89579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital (Street or Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry B. Eversol

(a) RESIDENCE NO. 1917 Ridgewood (St.) Ave. WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Eversol

6 DATE OF BIRTH (month, day, and year) Nov 11 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper on Ice Wagon
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer American D & C Co

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Eversol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Eversol
(Address) 1917 Ridgewood Ave

15 Filed AUG 26 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Fractured Skull

(duration) 11 yrs. 5 mos.

CONTRIBUTORY (Secondary) accidentally Fell off Ice Wagon

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. B. Hutton, M. D.
(Coroner.)

1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8/20 1924
20 UNDERTAKER	ADDRESS
Geo. J. Rutt	1735 Harford Ave

INSTRUCTIONS: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89580

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1925 E. Hoffman St., 8 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Leora E. Roth

(a) Residence No... 1925 E. Hoffman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced.~~ (Write the word.) married

5a-If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Adam J Roth

6-DATE OF BIRTH (month, day and year) Dec 26-1872

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER Chas Melchen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sophia Fredrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant)... Adam J Roth

(Address) 1925 E Hoffman st

15- Filed AUG 20 1924, 192.. H. A. M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 18-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 9, 192 4, to Aug 18, 192 4, that I last saw h N alive on Aug 18, 192 4, and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death?... Date of...

Was there an autopsy?...

What test confirmed diagnosis?...

(Signed) Jacob Frohn, M. D.

8/19, 192 4 (Address) 1823 N Washington st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cemetery — DATE OF BURIAL, Aug 21, 1924

20-UNDERTAKER. Robt J Young Sr — ADDRESS 1492 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89581 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89581

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Carey ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. James M. Bradie Bradley

(a) RESIDENCE. NO. 716 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Am Tea Wagon

(c) Name of employer Am Tea Co.

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Willis J.M. B. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Eleanora Burley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Mrs. Susie Johnson

(Address) 716 N. Carey St

Filed AUG 20 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12th 1924, to Aug. 18th 1924, that I last saw h alive on Aug. 18th 1924, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. C. Bell M. D.

. 19 (Address) 1124 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemtery

DATE OF BURIAL Aug 21 1924

20 UNDERTAKER Mr S James W. Dennis

ADDRESS 1303 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 89582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89582

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Lorman ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Barnes

(a) RESIDENCE. No. 1607 Lorman ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Barnes.

6 DATE OF BIRTH (month, day, and year) May 7. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Scotland Md.

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John Barnes — (Address) 1607 Lorman St.

AUG 20 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Aug 18, 1924, that I last saw her alive on Aug 16, 1924, and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronica

(duration) yrs. 2 mos.? ds.

CONTRIBUTORY (Secondary) Gastro Enteritis Acute

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Wm A Wright, M. D.

Aug 19. 1924 (Address) 1309 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Co Md. Miller's whf.

DATE OF BURIAL Aug 20 1924

20 UNDERTAKER Mr. James H. Dennis

ADDRESS 1303 Preston St.

Rev. J. E. Nelson.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89583 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 1812 Wilhelm St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F. Munk

(a) Residence No. 1812 Wilhelm St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Munk

6-DATE OF BIRTH (month, day and year) Jan 1 1856

7-AGE. 58 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Geo Skipper

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

11- (Informant) John Le. Munk

(Address) 1812 Wilhelm St

15- AUG 20 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 8 1924 to Aug 18 1924

that I last saw h.. alive on Aug 18 1924

and that death occurred, on the date stated above, at 10.50 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 1 mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Bigler M. D.

8/19. 1924 (Address) 1729 E. Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL. Aug 21. 1924

20-UNDERTAKER. Josiah Lefer ADDRESS 1600 or North Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S Caren St. ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E Scott

(a) RESIDENCE. No. 204 S Caren ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator in Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Strauss Bros

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W Whitelaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Fannie Farley

(Address) 208 S Carey St.

15 AUG 20 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1924

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to August 18 1924

that I last saw her alive on August 18, 1924,

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility Exhaustion Lack of Nourishment

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard Strauss, M. D.

, 19 (Address) 1809 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 21 19

20 UNDERTAKER John J Fields ADDRESS 210 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89585

CERTIFICATE OF DEATH.

100-001 D 89585

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Clinton

(a) Residence No. 113 S. Dallas St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 49 yrs. mos. ds. (Given age)

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Mansfield (State or Country),

PARENTS.

10-NAME OF FATHER, Harry Clinton

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Eliza Viney

13-BIRTHPLACE OF MOTHER (city or town) ~~Md~~ (State or Country), Va

11- (Informant) Municipal Hospital Records

(Address)

15- Filed AUG 20 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-18-24

17- I HEREBY CERTIFY, That I attended deceased from 8-13 1924 to 8-18 1924

that I last saw h~~im~~ alive on 8-18 1924

and that death occurred, on the date stated above, at 7 45 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. ~~mos.~~ ~~ds.~~

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Bruce M. D.

8-19. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Laurel Cemetery	Aug 22. 1924
20-UNDERTAKER.	ADDRESS
Robert H. Williams	1515 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89586

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89586

CERTIFICATE OF DEATH.

1854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Mosher ST., 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Euda Ford.

(a) RESIDENCE No. 1126 Mosher ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	27	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Richard S. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Josephine Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Josephine Ford (Address) 1126 Mosher St

15 Filed AUG 20 1924, 192.. Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ..... yrs. ..... mos. 10 minutes ds.

CONTRIBUTORY (Secondary) Fell down stairs in home

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Aug 18, 1924 (Address) 28 Richardson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lot Mon — DATE OF BURIAL: Aug 20 1924

20 UNDERTAKER: Edward J. Hanley — ADDRESS: Balto

MARRIAGE LICENSE, WITH CERTIFICATE OF DEATH—THIS IS A PERMANENT RECORD. Every question on information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89587

CERTIFICATE OF DEATH.

54 D 89587

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2533 Oak St ; ST.; 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rupard Atkins

(Residence in Baltimore: No. 2533 Oak St ; St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... 5 (Month) — 28 (Day), 1874 (Year)

7-AGE, 50 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wiley Good

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Rapann Good

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ulus Atkins

(Address) 2533 Oak St

15-

Filed ..... Robert P. Harrison, Registrar.

AUG 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 8 (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14th 1924, to Aug 17 1924, that I saw h[illegible] alive on Aug 17th 1924, and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Previous Pneumonia

..... (Duration) 2 yrs. 5 mos. ..... ds.

(Signed) Jas C Carter M. D.

8-17-, 1924 (Address) 1063 Myrtle Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Aug 20, 1924

20-UNDERTAKER Samuel J Beasley ADDRESS 538 N Gilmor St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN, WHEN CONSULTED, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89588

CERTIFICATE OF DEATH.

118 D 89588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Ten Per alley ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Collison Harding

(a) RESIDENCE NO 1601 Ten Per alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Harding

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Griffin (Address) 1601 Ten Per alley

15 Filed ....., 192 Robert P. Harrison Registrar

G20 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation
Lumbar Hernia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
Probably (duration) yrs. mos. 3 ds.

(Signed) James H Beeler, Coroner, M. D.

Aug 20, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbury Cemetery	Aug 20 1924

20 UNDERTAKER Mrs R.G. Elliott ADDRESS 1125 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89589

CERTIFICATE OF DEATH.

90 D 89589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 W. Lanvale ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse B. Jones

(a) RESIDENCE No. 521 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Missouri King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Bertha Payne (Address) 521 W. Lanvale St.

15 Filed ....., 192 ..... Registrar

G 20 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Organic Heart disease

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hemelsoy, M. D. (Coroner.)

Aug. 18, 1924 (Address) 2 E Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Clayburn	Aug 21 24
20 UNDERTAKER	ADDRESS
Jesse L. Peddicord	436 N. Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89590

CERTIFICATE OF DEATH.

9 D 89590

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Ashland Ave St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest E. Ridgely

(Residence in Baltimore: No. 1013 Ashland Ave St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	B	Single

6-DATE OF BIRTH, Oct 2 (Month) (Day) 1922 ~~1920~~ (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 10 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Ridgley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Florence Baker

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ridgley

(Address) 1013 Ashland Ave.

15-

Filed.....Robert P. Harrison.....
Registrar.

06 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1924, to Aug 18 1924, that I saw him alive on Aug 18 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration).....yrs.....mos.....14.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration).....yrs.....mos.....7.....ds.

(Signed) A. L. Wonderlich M. D.

8/18, 1924 (Address) 733 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Aug 20, 1924

20-UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1222 Ashland ave

Spec.—1-10-21—M&T—1500 Bks.

(Jones)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89591

CERTIFICATE OF DEATH.

7408 D 89591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N Saratoga ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Jones

(a) RESIDENCE NO. 1525 N Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE 41 Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED Laundress

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Augusta Johnson (Address) 1525 N Saratoga St

15 AUG 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-17-24, 19..., to 8-18-24, 19...

that I last saw her alive on " 19...

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) debility, arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lillard Gaw, M. D.

8-19-24 (Address) 1524 Druid Lane.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ant Auburn Cem DATE OF BURIAL Aug 21 1924

20 UNDERTAKER Brown & Leland ADDRESS 1140 N

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89592

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St. Balto Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances Clement

(a) Residence No. 2014 Harlem Ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 15. 1923

7-AGE. 1 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Francis Clement

11-BIRTHPLACE OF FATHER (city or town) (State or Country). do not Know

12-MAIDEN NAME OF MOTHER. Helen —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do not Know.

14- (Informant) Frances Clement

(Address) 2014 Harlem Ave.

15- Filed ..... 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

G 2 0 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/20/24

17- I HEREBY CERTIFY, That I attended deceased from 8/16 19 24 to 8/20 19 24, that I last saw him alive on 8/20 19 24, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

I. B. Meningitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Spinal Fluid

(Signed) Francis H Hillin M. D.

19 (Address) Hagan Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem.	Aug 21 T. 1924
20-UNDERTAKER. John J Cowan & Son J. J. Cowan	ADDRESS 901 Hollins St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89593

CERTIFICATE OF DEATH.

D 89593

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital Ward 16 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casper Wiedman

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1861

7-AGE 63 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clock Maker 039

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Switzerland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14- (Informant) Hospital Records

(Address) Bay View Hospital

AUG 20 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

1708

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 17-1924

17- I HEREBY CERTIFY, That I attended deceased from 8/17, 19.24 to 8/17, 19.24

that I last saw h. alive on 8/17, 19.24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sternum

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Lab Test.

(Signed) W. P. Campen, M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 19....

20-UNDERTAKER. ADDRESS

Commissioner of Health.

Rec. Wm. E. WOODALL

UNIVERSITY OF MARYLAND

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89594

D 89594

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 Booth ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Schmelz

(a) RESIDENCE. No. 2238 Booth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John Schmelz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary Weckesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) John. Schmelz 517 N. Schroeder St

15 Filed AUG 20 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1924, to Aug 20, 1924, that I last saw her alive on Aug. 20, 19 24, and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Fever.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Robt K Blake, M. D.

, 19 (Address) 1014 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Aug 21st 1924
20 UNDERTAKER	ADDRESS 517 N Schroeder St
H. C Brannigan Son	

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89595

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Maryland Ave. Brooklyn. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Smart.

(a) RESIDENCE No. 525 Maryland Ave. Brooklyn. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Lady C. Smart.

6 DATE OF BIRTH (month, day, and year) February 21, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Furniture salesman.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Staunton, Va.
(State or country)

PARENTS

10 NAME OF FATHER Moses V. Smart.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) New Hampshire.

12 MAIDEN NAME OF MOTHER Sally F. Ast.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia.

14 Informant Lady C. Smart (wife)
(Address) 525 Maryland Ave Brooklyn.

15 Filed AUG 20 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt, (Coroner) M. D.

Aug. 19, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Staunton Va	Aug 22 1924

20 UNDERTAKER	ADDRESS
A. Howard Evans	828 E. Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89596

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Julianna Pocko

(a) RESIDENCE NO. 192 Fayette St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Piskor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Eva —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record.
(Address)

15 Filed AUG 20 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/24

17 I HEREBY CERTIFY, That I attended deceased from 8/14/24, 19..... to 8/19/24, 19..... that I last saw h alive on 8/19/24 and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Cholecystitis

Acute Parenchymatous Nephritis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Aug. 23, 1924.
20 UNDERTAKER	**ADDRESS**
M. J. Sadowski.	705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89597

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1427 Aisquith St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lottie May Malone

(a) Residence No. 1427 Aisquith St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 16, 1923

7-AGE. ..... yrs. 9 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Md.

PARENTS:

10-NAME OF FATHER. Eugene H. Malone

11-BIRTHPLACE OF FATHER (city or town). Balto
(State or Country), Md

12-MAIDEN NAME OF MOTHER. Beatrice Murphy

13-BIRTHPLACE OF MOTHER (city or town). Balto
(State or Country), Md

14- (Informant). Eugene H. Malone

(Address). 1427 Aisquith St.

15- Robert P. Harrison, Registrar.

AUG 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 19 24 to Aug 19 19 24

that I last saw h[illegible] alive on Aug 18 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mes Colitis.

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens, M. D.

8/19, 1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral — DATE OF BURIAL. Aug. 22, 1924

20-UNDERTAKER. Margaret G. Flynn — ADDRESS 1422 Eight St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 89598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1605 E. 28th St.; 9 WARD)

REGISTERED No. C 160

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louise Taylor.

(Residence in Baltimore: No. 1605 E. 28th St.; ...yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. (Month) 19 (Day), 1924 (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, 1 hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work /
(b) General nature of industry, business, or establishment in which employed (or employer) /

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, John T. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Helena M. McClain

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Taylor

(Address) 1605 E. 28th St.

15- AUG 20 1924 Robert P. Harrison, 191... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 19th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 19th 1924, to Aug. 19th 1924, that I saw h[illegible] alive on Aug. 19th 1924, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema /

/ (Duration) ...yrs...mos. 1 ds.

CONTRIBUTORY (Secondary) Complications in Mother at time of birth (Duration) ...yrs...mos. 1 ds.

(Signed) Wm. J. Tillsbury M. D.

Aug. 20, 191... (Address) 4152 Cedar Park Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Leadenhall Cemetery	Aug 22, 191...
20-UNDERTAKER	ADDRESS
Eby Geo. E.	501 E. Lanvale St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89599

D 89599

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605 E. 28th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena M. Taylor

(a) Residence No. 1605 E. 28th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) John T. Taylor

6-DATE OF BIRTH (month, day and year) Aug. 27th, 1905

7-AGE. 18 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home work.

(b) General nature of industry, business, or establishment in which employed (or employer): Own home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS:

10-NAME OF FATHER. William W. Lyle

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary Gordon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Harford Co. Md.

14-Informant. John T. Taylor.

(Address) 1605 E. 28th St.

15-Robert P. Harrison, Registrar.

G 2 0 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 19/1924

17-I HEREBY CERTIFY, That I attended deceased from Aug. 19th 1924 to Aug. 19 1924 that I last saw h.. alive on Aug. 19th 1924 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardia Insufficiency

(Duration) ....yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) Purpura & Eclampsia

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Convulsions

(Signed) William J. Pillsbury, M. D

Aug 19, 1924 (Address) #15 Pedcroft Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. Aug 22, 1924

20-UNDERTAKER. John Leech & Son

ADDRESS E. Lanvale

WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Grim

D 39600 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2867 Ed Lafayette St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Grim

(a) Residence No. 2867 Ed. Lafayette St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Married~~, Widowed, or Divorced. (~~Write the~~ word.) Widowed

6a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Henry F. Grim

6-DATE OF BIRTH (month, day and year) July 26, 1874

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Home
(b) General nature of Industry, business, or establishment in which employed (or employer). 037
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Robert Gardner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Fort Deposit Md

12-MAIDEN NAME OF MOTHER. Sarah Jacobs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) E. F. Grim (Address) 2867 Ed Lafayette

15- Filed AUG 20 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 18-24

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to Aug 18, 1924 that I last saw her alive on Aug 18, 1924 and that death occurred, on the date stated above, at 11.25 A.M. The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis,

(Duration) 1 yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. T. Hennessy M. D

Aug 20, 1924 (Address) 2502 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Aug 21, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 507 E Monument Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89601

D 89601

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 14 WARD)

2-FULL NAME Mrs. Harry Sauerwein

(a) RESIDENCE NO. 1534 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Sauerwein

6 DATE OF BIRTH (month, day, and year) July 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Sauerwein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary McCabe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Sauerwein (Address) 2449 N. Calvert St

15 Filed AUG 20 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1924, to Aug. 19, 1924, that I last saw h~~im~~ alive on Aug. 19, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia with
a Myo-cardial manifestation
Cancer of stomach

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Yes Date of 8/11/24

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) ..... M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 21 1924
20 UNDERTAKER E. A. Friedfeld &	ADDRESS 510 E 23 St

A.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Bks.

D 89602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89602

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mc Gen. Hospital ST. WARD)

2-FULL NAME Mrs Mary Susan Brooks

(a) RESIDENCE NO. Farm Glen Rd. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 22 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrison Obalot Co Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Towns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) La

14 Informant J. W. Brooks

(Address) Farm Glen Rd

AUG 29 1924

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-24

17 I HEREBY CERTIFY, That I attended deceased from 8-7-24 to 8-20-24, 19..., that I last saw h alive on 8-20-24, 19..., and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. A. Tompkins, M. D.

, 19 (Address) Mc Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Farm Grove Rd

DATE OF BURIAL Aug 22 1924

20 UNDERTAKER H. B. Stabler

ADDRESS Farm Grove Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89603

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 89603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. B. & O. Grain Elevator ST., Locust Point WARD 18)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin M. Stephens.

(a) RESIDENCE NO. 1072 W. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~XXXXXXXX~~ Ida A. Stephens.

6 DATE OF BIRTH (month, day, and year) March 25, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician helper.

(b) General nature of industry, business, or establishment in which employed (or employer) 024

(c) Name of employer L. K. Comstock & Co.

9 BIRTHPLACE (city or town) (State or country) Calhoun, Ga.

PARENTS

10 NAME OF FATHER John Stephens.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant George B. Stephens. (son)

(Address) 1072 W. Fayette St.

15 Filed AUG 20 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day, and year) August 18, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy of inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and spine.
Accidental fall from roof of a grain galley.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.

(Coroner)

Aug. 19, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem

DATE OF BURIAL 8-22 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89604

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 89604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie M. Glenn

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... Unknown
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 Robert P. Harrison Registrar

AUG 20 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-1, 1922 to 8-19, 1924.

that I last saw her alive on 8-19, 1924

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude C. Drace, M. D.

8-20 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	8/22 1924
20 UNDERTAKER Robert Brookes	ADDRESS Calhoun & Orleans

A.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89605

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1213 Bolton St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Estella B. Ellison

(a) Residence No. 1213 Bolton St., 11 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (~~Write the word.~~) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible] 1869

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Howard City Md

PARENTS.

10-NAME OF FATHER, Henry Garner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER, Estella Garner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Howard Co Md

14-(Informant) Mrs. Augusta Lemba

(Address) 1213 Bolton St

15-

AUG 20 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30th, 1923, to Aug 19th 1924 that I last saw h[illegible] alive on Aug 18th 1924, and that death occurred, on the date stated above, at 6.30a, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast involving glands of neck.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. D. Englehart M. D

8, 20, 1924 (Address) 211 W. Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Line from West'n

DATE OF BURIAL. 8/21, 1924

20-UNDERTAKER. Robert Berkeson

ADDRESS Calhoun Hollins

No. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Merck)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89606

74-B 89606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1011 N Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Jacob Merck

(a) Residence No. 1011 N Wolfe St., 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~or Married~~, Widower or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Theresa Merck

6-DATE OF BIRTH (month, day and year) dont Know

7-AGE, 84 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Milk Business

(b) General nature of Industry, business, or establishment in which employed (or employer)... * Grocer

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), dont Know

12-MAIDEN NAME OF MOTHER, dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) Louis Merck (His Son)

(Address) 1011 N Wolfe St

15- Filed ... 192 ... Registrar.

Robert P. Harrison,

AUG 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 19/24

17- I HEREBY CERTIFY, That I attended deceased from January 20th 1924 to August 18th 1924

that I last saw him alive on August 18th 1924

and that death occurred, on the date stated above, at 4.50 pm.

The CAUSE OF DEATH* was as follows:

Senile Degeneration — Debility

(Duration) yrs. 7 mos. 11 ds.

CONTRIBUTORY (Secondary) Pachyma of Brain

Chronic Hemichagia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thomas J. Symms M. D

. 19 (Address) 1025 N Wolfe St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL, Aug 21, 1924

20-UNDERTAKER, Frank Crockson — ADDRESS 1906 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89607

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

D 89607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 837 S Montford Ave Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Leik

(a) Residence No. 837 S. Montford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 21 - 24

7-AGE,	If LESS than 1 day,
5 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:

10-NAME OF FATHER Sam Leik

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Anna Bystryk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Sam Leik

(Address) 837 S Montford Ave

15-

Filed ..... 192.... Registrar.

AUG 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 20. 1924

17. I HEREBY CERTIFY, That I attended deceased from August 17, 1924 to Aug. 20, 1924

that I last saw her alive on Aug. 20 1924

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Andrew Kunkowski M. D.

, 19 (Address) 3539 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Rosary	Aug 21 1924

UNDERTAKER. ADDRESS

F. W. Czazenski 1930 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89608 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89608

16-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 W Franklin ST. 19 WARD)

2-FULL NAME Harold E. Griffin

(a) RESIDENCE. No. 1405 W Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 19 24

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Anthony P. Griffin

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Noomi V. Turner

13 BIRTHPLACE OF MOTHER (city or town) a.a.c.
(State or country) Md.

14 Informant Mrs. Griffin
(Address) 1415 N Franklin St.

15 [illegible] AUG 21 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1924, to Aug 20, 1924, that I last saw h[illegible] alive on Aug 20, 1924 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Two months gestation)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) W. P. L. Campbell, M. D.

Aug 21 19 24 (Address) 1644 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 21, 1924
20 UNDERTAKER John F. Cowan & Son	ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89609

CERTIFICATE OF DEATH.

1446 D 89609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 10 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Matoba Futodo.

(a) RESIDENCE NO. 823 Hartford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1891

7 AGE: Years 33; Months; Days; If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chas Co, Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Respectful Friend

15 Filed AUG 21 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/12/1924

17. I HEREBY CERTIFY, That I attended deceased from 7/7/24 19.. to 8/12/24 19.. that I last saw her alive on 8/12/24 and that death occurred, on the date stated above at 7.45 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Metritis Endometritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. L. Gay M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem DATE OF BURIAL 8/24/24

20 UNDERTAKER: Saml D Hawley ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89610 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Eutaw St. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosetta Kiah. (C)

(a) RESIDENCE No. 802 S. Eutaw St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred --- yrs. 2 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of !!!!!!!!!!!!

6 DATE OF BIRTH (month, day, and year) March 16, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	---	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Sherwood Kiah. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Bertha Woolford. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Bertha Kiah. (C) mother.
(Address) 802 S. Eutaw St.

15 Filed ....., 192 ..... Registrar

AUG 21 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Aug. 20, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 21 192 4
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Hundred Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89611

CERTIFICATE OF DEATH.

1794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Denwood Coster

(a) RESIDENCE NO 3033 E. Monument St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Mch. 4th. 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Newton C. Coster

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha K. Wirth

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Newton C. Coster
(Address) 3033 E Monument St.

15 Filed AUG 21 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns of body accidental

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Aug 20 H. 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/22/24 192

20 UNDERTAKER H. E. Hughes, 424 N. Broadway

ADDRESS

should be stated EXACTLY. PHYSICIAN
t may be properly classified. Exact statement of OCC
n back of certificate.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 89612

174/104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 (WARD)

2-FULL NAME Anita Rosenbergex

(a) RESIDENCE NO. 4022 Philadelphia St., Road
(Usual place of abode)

Length of residence in city or town where death occurred 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 4, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edmund Rosenberge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Magaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records
(Address) Johns Hopkins Hospital

15 AUG 21 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1924, to August 19, 1924, that I last saw her alive on August 19, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Poliomyelitis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund W. Kerpen, M. D.

8/20, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Aug 21 1924

20 UNDERTAKER John Meerics — ADDRESS Edeam

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

1736 D 89613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4it D 89613

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georg Bamberger

(a) RESIDENCE NO. 637 S. Bunker ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret C. Bamberger

6 DATE OF BIRTH (month, day, and year) Aug 30th 1883

7 AGE 41 Years | Months 11 | Days 20 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Caspar Bamberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Deemler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address)

AUG 21 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to August 20, 1924, that I last saw him alive on August 20, 1924, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus of stomach & involved pancreas and regional glands

(duration) ... yrs. 6 mos ...

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Yes Date of July 30, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Julius A. Thomsen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether (Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Aug 23 1924

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89614

17409 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89614

1-PLACE OF DEATH Johns Hopkins Hospital (WASSERMAN) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. WARD)

2-FULL NAME Leonard Wasserman

(a) RESIDENCE No. 143 N. Streeper ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) July 18 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Leonard Wasserman (WASS MAN)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wasserman (WASS MAN)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records

(Address) Johns Hopkins Hospital

15 AUG 21 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from August 16, 1924 to August 20, 1924, that I last saw him alive on August 20, 1924, and that death occurred, on the date stated above, at 7:05 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea 4 weeks

Vomiting 2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund N. Kuper, M. D.

8/21 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeem

DATE OF BURIAL: 8/21/1924

20 UNDERTAKER: L. G. Doran

ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

D 89615

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-D 89615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Lapin

(a) RESIDENCE No. 1818 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Charles Lapin

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 48; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abe Duke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hannah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 E. Pratt St

15 Filed AUG 21 1924 LLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 20, 1924.

that I last saw h— alive on Aug 20, 1924

and that death occurred, on the date stated above, at 11.05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) — yrs. — mos. 12 hrs

CONTRIBUTORY (Secondary) Auto thyrotoxicosis

(duration) about 1 mos — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Adler Smithemier, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Co

DATE OF BURIAL: 8/21 19 24

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E. Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39616

101 D 39616

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 N Fayette St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles S. Sharp.

(Residence in Baltimore: No. 831 N Fayette St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Ironworker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lucas County O Md

PARENTS.

10-NAME OF FATHER, Wm L Sharp

11-BIRTHPLACE OF FATHER (State or Country), Md. Caroline Co

12-MAIDEN NAME OF MOTHER Mary Marshall

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mamie Sharp

(Address)..... Canton Md

15- AUG 21 1924 GG
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 19 1924, to Aug 20 1924, that I saw h im alive on Aug 20 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. 14 ds.

(Signed) H. M. King M. D.

8-20, 1924 (Address) 625 N Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 8-21, 1924

20-UNDERTAKER J. J. Daley & Sons — ADDRESS 131 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 89617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89617

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 Holly Ave (St.) 27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris V. Stehli

(a) RESIDENCE NO. 10 Holly Ave. (St.) Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: C. C. Stehli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Dora L. Ignatius

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: C. C. Stehli

(Address): 10 Holly Ave

15 Filed ..... 19 ..... Registrar

AUG 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1924, to Aug. 19, 1924, that I last saw her alive on Aug. 19, 1924, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Richetts

(duration) yrs. 2 mos. (?) ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. M. Bacon, M. D.

8/20 1924 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: 8/21 1924

20 UNDERTAKER: J. J. Fahey & Sons

ADDRESS: 1318 E. Fayette St

Spec—12-23-21—E.B.R.S.—400 Bks.

Luigi Cadeo

D 89618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 89618

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St. W 2nd A. Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Luigi Cadeo

(a) Residence No. Bay View Asylum St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? Unknown yrs. Unknown mos. Unknown ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1843

7-AGE. 81 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city (State or Country), Unknown

11- (Informant) Hospital Records

(Address) Bay View Hospital Ward A

15- AUG 21 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/20/24

17- I HEREBY CERTIFY, That I attended deceased from 8/19, 1924 to 8/20 1924 that I last saw h. alive on 8/20 1924 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia 7 days

also Marked Senile Arteriosclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. Tests

(Signed) H. P. Champe, M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Aug 21, 1924
20-UNDERTAKER. H. W. Memler & Son	ADDRESS. 800 N Caroline

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89619

CERTIFICATE OF DEATH.

16-001 D 89619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nuth

(a) RESIDENCE NO. 5318 Maple Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug. 15, 1924

7 AGE Years Months Days If LESS than 1 day, hrs or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant MD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Woman's Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Elsworth Nuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Martha Cover

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carrol County Md.

14 Informant: Joseph Elsworth Nuth

(Address): 5318 Maple Ave Baltimore

15 Filed AUG 21 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to aug 15th, 1924, that I last saw him alive on Aug. 15th, 1924, and that death occurred, on the date stated above, at 6.09 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Frederick A. Snyder M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Retained by hospital for scientific purposes

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89620

CERTIFICATE OF DEATH.

1735 49

1-PLACE OF DEATH John Hopkins Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., 13 WARD)

2-FULL NAME Arnold Kutner

(a) RESIDENCE No. 2574 Druid Park Dr. WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mak	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J Kutner

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) — 268

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Isadore Kutner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ernestine Bro...

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records John Hopk... Hospital

15 Filed ... Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to Aug 20, 1924.

That I last saw him alive on Aug 20, 1924,

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 4, 1924

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Hunt, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park — DATE OF BURIAL aug 21 1924

20 UNDERTAKER Joseph Abrens — ADDRESS 221 Bway

AUG 21 1924

Burial Permit ...

Spec.—1-10-21—M&T—1500 Bks.

D 89621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 89621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Spring ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Johnson

(a) RESIDENCE NO. 224 S. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colord

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infent

6 DATE OF BIRTH (month, day, and year): aug 15 1924

7 AGE: Years | Months | 5 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infent ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): 224 S. Spring st Balto md

PARENTS

10 NAME OF FATHER: William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: George Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): George Johnson 224 S. Spring st

15 [illegible] AUG 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1924, to Aug 20, 1924, that I last saw him alive on Aug 21, 1924, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) M N Gutterman, M. D.

Aug 21, 1924 (Address) 221 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery

DATE OF BURIAL: aug 23 1924

20 UNDERTAKER: Edward Bryan

ADDRESS 631 orleans st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 3482

D 39622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X131 D 89622

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Getz

(a) RESIDENCE NO. Reading Pa. ST., WARD Reading Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes Getz

6 DATE OF BIRTH (month, day, and year) Jan 19 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Hiram Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Sarah Kistler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant (Address) Records John Hopkins Hospital

15 AUG 21 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1924

17 I HEREBY CERTIFY, That I attended deceased from ~~July~~ 18, 1924, to Aug 21, 1924, that I last saw ~~he~~ alive on Aug 21, 1924, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pyelonephritis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Reading Pa

Did an operation precede death? yes Date of Aug 12-24

Was there an autopsy? yes.

What test confirmed diagnosis? Blood urea + autopsy

(Signed) Robert McKay, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reading Pa — DATE OF BURIAL Aug 28 1924

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 205 N Calvert St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89623

CERTIFICATE OF DEATH.

13 D 89623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital) (St. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ethel Harrington

(a) RESIDENCE NO. Old Orchard Rd. ST. Ten Hills WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 8 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W Stuart Harrington

6 DATE OF BIRTH (month, day, and year) Nov 21 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer .....

9 BIRTHPLACE (City or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Chas W Schaefer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Ursula Eisenhardt

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Hospital Record

15 AUG 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/24

17 I HEREBY CERTIFY, That I attended deceased from 7/14/24, 19..., to 8/20/24, 19..., that I last saw h[illegible] alive on 8/20/24 at 1.00 P. m. and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis.

(Duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Golley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	AUG 22 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Lights

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89624

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Hanover ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. Sullivan

(a) RESIDENCE. No. 1001 Hanover ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvina Sullivan

6 DATE OF BIRTH (month, day, and year) Sept 14-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer) Dtl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Annie Sheehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs Annie Rossiter
(Address) 1001 Hanover st

15 Filed AUG 21 1924, 19 Robert P. Harrison,
Registrar
Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 19. 1924.

17 I HEREBY CERTIFY, That I attended deceased from 8. 12. 1924. to 8. 19. 1924

that I last saw him alive on 8. 19. 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

8. 20. 1924 (Signed) J. Edward Norris, M. D.
(Address) 107 E West st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 22 '24
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 89625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X49 D 89625

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital 6th St. WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Grove

(Residence ~~in Baltimore;~~ No. Hanover Pa

St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1876 (Year)

7-AGE, 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Traveling Agt
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Granville Grove

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Emma Hartman

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry Grove

(Address) 105 York St Hanover Pa

15- Robert F. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk

AUG 21 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of Bladder

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Morrison M. D. (Coroner.)

Aug 21, 1924 (Address) 3692 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hanover Pa — DATE OF BURIAL, Aug 21, 19..

20-UNDERTAKER Wm J Tuckerman — ADDRESS North St Pa

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 89626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89626

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2921 N Calvert St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hindes Daneker

(a) Residence No. 2921 N Calvert St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 4 1839

7-AGE 84 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired P.O. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Daneker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Ann Sarvis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) C V Daneker

(Address) 2921 N Calvert

15- Filed AUG 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 20 '24

17- I HEREBY CERTIFY, That I attended deceased from June 8, 19.24, to Aug 20, 19.24 that I last saw him alive on Aug 20, 19.24 and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F. Goldsborough, M. D.

, 19 (Address) 2923 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Aug 22, 1924
20-UNDERTAKER,	ADDRESS
Wm J Tudor & Son	Norman

GIVE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—see instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89627

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. 16 St.) (WARD)

2-FULL NAME Wm H. Worley

(a) RESIDENCE NO. 1215 N. Stricker St. (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Worley

6 DATE OF BIRTH (month, day, and year) Feb. 14. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70 yrs	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moving Van Bus

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Alexander Worley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary A Worley
Address 1215 N. Stricker St

AUG 21 1924
Filed , 19

Robert F. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1924, to Aug 20th, 1924, that I last saw him alive on Aug 20, 1924, and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Mannuger M. D.

Aug 20th 1924 (Address) Colonial Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug. 24 1924
20 UNDERTAKER Wm Tickner Sons	ADDRESS Norfolk Va

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89628 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89628

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen. Hosp. (St.) 15 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Mertz Sr.

(a) RESIDENCE No. 2710 Garrison Ave. (St.) ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE OF Mrs Louis Mertz Sr.

6 DATE OF BIRTH (month, day, and year) July 27 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	0	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Philip Mertz (Germany)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Margaret Eckhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant (Address) Mrs Louis Mertz 2710 Garrison Ave

15 Filed AUG 27 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1924, to Aug 21, 1924, that I last saw him alive on Aug 21, 1924, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Ulcer duodenum
Arteriosclerosis and chr. hyperplastic nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 20, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

(Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Aug 23, 1924

20 UNDERTAKER Wm J Pickrell & Sons — ADDRESS Norfolk Va

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

89629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 598½ W. Preston St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Jones

(a) Residence No. 598½ W. Preston St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Howard Jones~~

6-DATE OF BIRTH (month, day and year) ~~Unknown~~ 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, George Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md.

12-MAIDEN NAME OF MOTHER, Mary Chase

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Lucy Jones

(Address) 598½ W. Preston St.

15- Filed ..... 192 Robert F. Harrison, Registrar.

Burial Permit Clerk.

AUG 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 19-1924

17- I HEREBY CERTIFY, That I attended deceased from August 3rd 1924 to Aug 19 1924

that I last saw him alive on August 18 1924

and that death occurred, on the date stated above, at 7.15a m.

The CAUSE OF DEATH* was as follows:

Convulsions & Heart failure

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Lungs

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Wilkerson M. D

, 19 (Address) 708 Ensor St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	8/22 1924
20-UNDERTAKER.	**ADDRESS**
John H. Todvin	1027 Druid Hill Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39630 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 39630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at St Joseph Hospital 14

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madison F Kenwell

(a) RESIDENCE No. 1413 Myrtle Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 13-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Chas Co Md

9 BIRTHPLACE (city or town) Washington
(State or country) D C

PARENTS

10 NAME OF FATHER Washington Kenwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Beckon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Jessie Kenwell
(Address) 1413 Myrtle Ave

15 AUG 24 1924 G G Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) 1 yrs. mos. 1 ds.

(Signed) James M Kerr Jr M. D.
(Coroner.)

Aug 16, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Aug 22 1924

20 UNDERTAKER Samuel T Kemsley ADDRESS 1128 Eutaw

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 39631

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 226 Homewood Ter St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Celia Frances Perry

(a) Residence No. 226 Homewood Ter St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Wm. H. H. Perry

6-DATE OF BIRTH (month, day and year) Oct. 27 1852

7-AGE. 71 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Willis Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Margaret F. Patchett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Mr. Harry O. Perry

(Address) 226 Homewood Ter.

15- Filed AUG 22 1924 G G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 19 24 to Aug 20 19 24

that I last saw h[illegible] alive on Aug 11 19 24

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma right hip (

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Wheaton M. D.

19 (Address) 4239 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Preston - Md. DATE OF BURIAL. Aug 22 1924

20-UNDERTAKER. Wm. Fickner Sons ADDRESS North Ave

NO. 3. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Frances Elizabeth Pryor)

D 89632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89632

1-PLACE OF DEATH Howard A. Kelly Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 141 & Eutaw Pl. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Wm~~ Frances Elizabeth Pryor

(a) RESIDENCE NO. 22 Madison Ave ST., WARD Hagerstown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Wm Pryor

6 DATE OF BIRTH (month, day, and year) April 18 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carotown Maryland

PARENTS

10 NAME OF FATHER Geo. W. Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Georgette Lyday

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant W. L. Cross

(Address) Hagerstown Md R.F.D. 6

15 AUG 22 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1924 to Aug 21 1924

that I last saw her alive on Aug 21 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH was as follows:

General Sarcomatosis

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Sarcoma body of uterus (duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Grant Ford M. D.

, 19 (Address) 141 & Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md — DATE OF BURIAL aug 22 1924

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. Fourth ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39633

HEALTH DEPARTMENT—CITY OF BALTIMORE

4d D 39633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 229 S. Ellwood Avenue, 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. George L. Frederick

(a) Residence No. 229 S. Ellwood Avenue, Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Frederick

6-DATE OF BIRTH (month, day and year) Oct 16, 1861

7-AGE.	If LESS than 1 day,
62 yrs. 10 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Baltimore

PARENTS:

10-NAME OF FATHER, Micheal Frederick

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Wenerger

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany

14- (Informant) Emma M. Frederick
(Address) 229 S. Ellwood Ave

15-

Filed..... 192.....

AUG 22 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1924 to Aug. 20, 1924

that I last saw him alive on Aug 20, 1924

and that death occurred, on the date stated above, at 8 30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of Aug 5 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. Bridenbaugh M.D.

Aug 21 1924 (Address) 1318 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Paul's Cem	Aug 22, 1924
20-UNDERTAKER	ADDRESS
H. Sander Son	1710 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

Dr. Fisher

D 89634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89634

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 S. Chapel St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Estella Elizabeth Jones

(a) Residence No. 520 S. Chapel St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Jones

6-DATE OF BIRTH (month, day and year) Dec 17 1889

7-AGE. 34 yrs. 8 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

037

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Author McGinnis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Emma Müsch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Edward Jones

(Address) 520 S. Chapel St

15-

Filed AUG 22 1924 192.... G G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924 to Aug 19, 1924

that I last saw h[illegible] alive on Aug 19 1924

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel A. Fisher, M. D.

, 1924 (Address) 325 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cem	Aug 22, 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1700 Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mamie Camphor

D 89635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 89635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 Wilkens ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Compher

(a) RESIDENCE. No. 123 Wilkens ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 1857

7 AGE: Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Harry Cornish

(Address) 123 Wilkens alley

15 Filed AUG 22 1924 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1924, to Aug 19, 1924, that I last saw h[illegible] alive on Aug 19, 1924 and that death occurred, on the date stated above, at 9.05 P, m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ac Stenosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H. Hosten M. D.

(Address) 712 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 22 1924
20 UNDERTAKER	ADDRESS
S. E. Brown & Son	101 N Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89636

CERTIFICATE OF DEATH.

100 801 D 89636

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME James H. Barnes

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. — ds. — How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Municipal Hospital Records
(Address)

15 AUG 22 1924 G.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1923, to 8-20, 1924 that I last saw him alive on 8-20, 1924 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sob

(Signed) Claude A. Jones, M. D.

8-20 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakey Cemetery	Aug 22 1924

20 UNDERTAKER Miss Thos G. Bailey

ADDRESS 1421 Jefferson St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89637 HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D 89637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1720 N Behtel St. St., ... Ward) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mulligan.

(a) Residence No. 1720 N Bethel St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 2 1923.

7-AGE.	If LESS than 1 day.
1 yrs. 1 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George T Mulligan.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Elmore Schultz.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14- (Informant) George T Mulligan.
(Address) 1720 N Bethel St.

15-
Filed ..... 192.....
AUG 22 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). AUG 21 1924

17- I HEREBY CERTIFY, That I attended deceased from
AUG 20 1924 19..... to AUG 20 1924 19.....
that I last saw h. / M alive on AUG 20 1924 19.....
and that death occurred, on the date stated above, at 10 30 A m.
The CAUSE OF DEATH* was as follows:
Acute Broncho Pneumonia

(Duration) X yrs. X mos. 3 ds. !

CONTRIBUTORY (Secondary) Probably Staph

(Duration) X yrs. X mos. 3 ds. !

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O H Dulker M. D.
AUG 21, 19 (Address) 928 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore	Aug 23/24 19....

20-UNDERTAKER.	ADDRESS
John Ullrich	2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89638

CERTIFICATE OF DEATH.

100-001

D 89638

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Brown

(a) Residence No. 3 N. Penal St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Gunning

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant) Municipal Hospital Records

(Address).....

15-Filed AUG 22 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-21-24

17-I HEREBY CERTIFY, That I attended deceased from 8-2, 1924 to 8-21, 1924 that I last saw h[illegible] alive on 8-20, 1924 and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + autopsy

(Signed) Claude 9. Drace M. D.

8-21, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Aug 23rd 1924

20-UNDERTAKER. A. Jones — ADDRESS. 1114 S. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-12-23—M&T—500 Bks.

D 89639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89639

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Hollins St. ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J Kaufman

(a) RESIDENCE NO. 1120 Hollins St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Kaufman

6 DATE OF BIRTH (month, day, and year) July 13, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Bailiff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... Germany
(State or country)

PARENTS

10 NAME OF FATHER John Kaufman

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Kestler

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Germany

14

Informant David Kaufman

(Address) 1120 Hollins St

Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1919, to Aug 20, 19 24,

that I last saw him alive on Aug 20, 19 24,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw V Coolahan, M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug 23, 24

20 UNDERTAKER F. B. Kuppert — ADDRESS 1850 W. Balto St

AUG 21 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89640

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 97 N. Monroe ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbia Posey

(a) RESIDENCE NO. 97 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: [redacted]

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F Posey

6 DATE OF BIRTH (month, day, and year): Feb 21 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): St Marys County Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys County Md

12 MAIDEN NAME OF MOTHER: Dorcas Hammett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys County

14 Informant (Address): Robt Posey 97 N Monroe St

15 Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to Aug 21, 1924, that I last saw her alive on Aug 21, 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

?

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Senile Coma

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Theo Wolfenden, M. D.

(Address) 1410 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 25 1924

20 UNDERTAKER: F. B. Keppert — ADDRESS: 1850 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1003 Busch St., 21 Ward) Registered No. 113

2-FULL NAME Albert Henry Deer Jr (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1003 Busch St., 21 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, or Divorced: (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 28-1923

7-AGE: yrs. 10 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer: Raymond Est Dept.

9-BIRTHPLACE (City or Town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Albert Henry Deer.

11-BIRTHPLACE OF FATHER (City or Town) (State or Country): Baltimore Md

MAIDEN NAME OF MOTHER: Mary J Thompson

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country): Baltimore Md

14-
(Informant): Albert H Deer
(Address): 1003 Busch St

AUG 22 1924

Filed ..., 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 to Aug 21 19 24

that I last saw h alive on Aug 21 19 24

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? no

What tests confirmed diagnosis?

(Signed) John G Schwenning M. D.

19 (Address) 1 N Wolfe St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 22nd 1924
20-UNDERTAKER	ADDRESS
John J Lequire & Son	901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 39642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39642

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3814 Kate Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta A. Huether

(a) RESIDENCE. No. 3814 Kate Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Huether

6 DATE OF BIRTH (month, day, and year): Mar 3 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Cornelius Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anne Schmidtberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Huether
(Address) 3814 Kate Ave

15 Filed AUG 22 1924, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 2 , 1924 , to Aug 21 , 1924 , that I last saw h[illegible] alive on Aug 20 , 1924 , and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Uremic Poisoning

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. C. Emmert , M. D.

(Address) 439 Eutaw Place Aug 21, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 23 1924

20 UNDERTAKER: Josiah Lyser ADDRESS: 1601 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Maffei

D 89643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Maffei

(a) RESIDENCE NO. 203 S. Eden St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Maffei

6 DATE OF BIRTH (month, day, and year) April 29. 1897.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
27.	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Vincenzo Rebecchi Melillo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Carmela Rebecchi

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Sabino Maffei
(Address) 203 S. Eden St.

15 Filed AUG 22 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrage & Vomiting
Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jno. M. Brown, M. D.
(Coroner.)

Aug 22, 1924 (Address) 309 Holden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Aug 23 1924
20 UNDERTAKER Wendell Coppel & Son	ADDRESS 37 Hanover

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 39644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39644

185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Youngheim

(a) RESIDENCE No. 2019 E. Biddle st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffuer 023
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frederick Youngheim

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Muth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14
Informant Frederick Youngheim
(Address) 2019 E. Biddle st

15
Filed AUG 22 1924
Registrar

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured skull, due to falling from [illegible] house. Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Lowman M. D.
(Coroner.)

Aug 22 1924 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 23 1924
20 UNDERTAKER Henry Lutz	ADDRESS 1203 W. Broadway

Cor.—1-12-23—M&T—100 Bks.

D 89645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N Eden ST., 5 WARD)

REGISTERED NO. 16120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Miller

(a) RESIDENCE No. 622 N Eden ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 12 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Salt City
(State or country)

PARENTS

10 NAME OF FATHER Charles Miller

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) X

12 MAIDEN NAME OF MOTHER Mildred Hawkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md & Va

14
Informant Mrs Mildred Hawkins
(Address) 622 N Eden St

15
Filed AUG 22 1922 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia, Lobar

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) & Mas Contusion

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm M Fenton, M. D.
(Coroner.)

Aug 18, 1924 (Address) Forensic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 20 1924
20 UNDERTAKER	ADDRESS
Chas H. Johnson	746 N. Carey St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89646

CERTIFICATE OF DEATH.

161-001 D 89646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 Fleet ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CLARA Matuszak,

(a) RESIDENCE NO. 1931 Fleet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 2/24.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) **********

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER Theodore Matuszak,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) MD.

12 MAIDEN NAME OF MOTHER Wanda Cholewsczewska,

13 BIRTHPLACE OF MOTHER (city or town) Poland, (State or country)

14 Informant Theodore Matuszak,

(Address) 1931 Fleet Street

15 Filed AUG 22 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22. 19 24.

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 19 24, to Aug 22, 19 24,

that I last saw h[illegible] alive on Aug 22, 19 24,

and that death occurred, on the date stated above, at 130-A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Rybowski, M. D.

19 24 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Aug 1924.

20 UNDERTAKER M F. Sadowski. ADDRESS 705 S. Wolfe

Spec.—1-10-21—M&T—1500 Bks.

D 89647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 652 Indiana Ave ST., 25 WARD)

REGISTERED NO. 161-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnora Edna Breen

(a) RESIDENCE No. 652 Indiana Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 7, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Patrick Breen

11 BIRTHPLACE OF FATHER (city or town) Wales, Md
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Tyler

13 BIRTHPLACE OF MOTHER (city or town) Wales, Md
(State or country)

14 Informant Patrick Breen
(Address) 652 Indiana Ave

15 Filed AUG 21 1924, 19.... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21, 1924

17

I HEREBY CERTIFY, That I attended deceased from August 19, 1924, to August 21, 1924,

that I last saw her alive on August 21, 1924,

and that death occurred, on the date stated above, at 12:55 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D. Walsh, M. D.

Aug 21, 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 22 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	531 W. Lombard

AUG 21 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89648

CERTIFICATE OF DEATH.

90 D 89648

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 N. Bond ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie E. Vinton

(Residence in Baltimore: No. 1408 N. Bond St.; ....yrs....mos....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S RECORD OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. (Month) 17 (Day), 1905 (Year)

7-AGE, 18 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Robt. S. Vinton Sr.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Rachael J. Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert S. Vinton Sr.

(Address) 1408 N. Bond st.

15. AUG 21 1924 Robert F. Harrison, ..., 191.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 20 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to Aug 20 1924, that I saw h.. alive on Aug 15 1924, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....
Epilepsy
.....
..... (Duration) 15 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) C. A. Hitchcock M. D.

8/22, 191.. (Address) Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Com. DATE OF BURIAL, Aug. 22, 1924

20-UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 89649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89649

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4407 Main ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney L. Shaw

(a) RESIDENCE No. 4407 Main ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Shaw

6 DATE OF BIRTH (month, day, and year) Aug. 21-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City (State or country) Md.

PARENTS

10 NAME OF FATHER John Lamy

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Mary Freeman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant's (Address) Mrs. Geo. D. Wever 4407 Main ave.

Filed AUG 22 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 21st, 1924, to Aug 21st, 1924, that I last saw h[illegible] alive on Aug 21st, 1924 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. C. Emmert, M. D.

(Address) 4209 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Aug. 23 1924

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

89650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89650

1-PLACE OF DEATH John Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Foster

(a) RESIDENCE NO. North Point Road (If non-resident give city or town and State) Sparrows Point Md.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 11 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Johnston Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Regds

(Address) John Hopkins Hosp

AUG 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 11 1924 to Aug 20 1924, that I last saw him alive on Aug 20 1924, and that death occurred, on the date stated above, at 11.30 P. m.

THE CAUSE OF DEATH* was as follows:

Birth Injury (Meningeal Hemorrhage)

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bagley M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
John Wesley Cem North Point Road	Aug 22 1924
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Callow Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks. (Isaac Williams)

D 89651 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89651

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Eislen ST. 72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isae Williams

(a) RESIDENCE NO 539 Eislen St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12/1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	1886	Oct		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lubaro Fla

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John Walker
(Address) 637 Eastern Ave

15 Filed 8-22, 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

8-22, 1924 (Address) 1128 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 22nd 24
20 UNDERTAKER	ADDRESS
Wm H Hoffman	406 N Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks. (Adolph Abel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89652 129 D 89652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1701. W. Durham

CITY OF BALTIMORE: (No.) Adolf Abel ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(a) RESIDENCE No. 1701. W. Durham ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman Abel (Address) 1701 W. Durham

Filed AUG 22 1924 192 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to.. death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Uremia due to
Bright's Disease
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Morrison, M. D.
(Coroner.)

Aug 22, 1924 (Address) 1932 Rolandson

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallas Cemetery — DATE OF BURIAL Aug 22 1924

20 UNDERTAKER Abbott Schuster Inc — ADDRESS 1 S Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89653

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1707 N. Register St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Unger

(a) Residence No. 1707 N. Register St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Unger

6-DATE OF BIRTH (month, day and year) Jan 1, 1850

7-AGE 74 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) dd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, John Riehl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " "

11- (Informant) Julius Unger

(Address) 543 E. 38th St

15- Filed AUG 21 1924, 19?

Robert F. Barnes, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 - 1923 to AUG 20 1924

that I last saw her alive on AUG 20 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

General Dementia with paralysis 8 months

x

(Duration) yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(Duration) 3 yrs. X mos. X ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of ? I. H. H.

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) O. H. Dukes M. D.

AUG 21 1924 (Address) 928 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore	Aug 23, 1924
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

R. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89654

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 502 N. Patterson Park St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bollinger

(a) Residence No. 502 N. Patterson Park ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marie

6-DATE OF BIRTH (month, day and year) May 31, 1884

7-AGE. 40 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Interior Decorator

(b) General nature of industry, business, or establishment in which employed (or employer) Self Employed

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. John Bollinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Sarah Vogel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Marie Bollinger

(Address) 502 N. Patterson Park ave

15- Filed ..... 192.. Robert F. Harrison Registrar.

AUG 22 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 9, 1924 to August 21, 1924 that I last saw h[illegible] alive on August 21, 1924 and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insufficiency
Pulmonary Tuberculosis-
Longstanding (4 mos)

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Phy. Exam

(Signed) Louis F. Krumrein, M. D.

, 19 (Address) 722 S. Kenwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. June 25, 1924

20-UNDERTAKER. Fielder & Pirkler — ADDRESS 1739 Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89655 (upper right)

CERTIFICATE OF DEATH.

D 89655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 Prospect Av ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Edward Krafft.

(a) RESIDENCE. NO. # 218 Prospect Av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 17-24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		5 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas. Edward Krafft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Grace Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

11 Informant (Address) Chas. Ed. Krafft 218 Prospect Ave.

Filed AUG 22 1924 . 19 Robert [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 17 . 1924. to Aug 21 . 1924.

that I last saw him alive on Aug 21 . 1924.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Immediate)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) # W. S. Reyel M. D.

. 19 (Address) 941 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	8/22 1924
20 UNDERTAKER Philip Henrig	ADDRESS 3046 Orleans

PLEASE PRINT WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 21 1924

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89656

CERTIFICATE OF DEATH.

161-001 D 89656

REGISTERED NO.....

1-PLACE OF DEATH 3106 Ellerslie Ave

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Connor

(a) RESIDENCE. NO. 3106 Ellerslie Ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Aug.21,1924

7 AGE	Years	Months	Days	If LESS than 1 day or Hours
				7 1-2

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work -----

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer -----

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James Patrick O'Connor

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine O'Neill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs Freeman
(Address) 2631 N Calvert St

15 Filed ..... 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

AUG 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.21 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 1924, 19..., to Aug.21 1924, 19...,
that I last saw her alive on Aug.21 1924., 19...,
and that death occurred, on the date stated above, at 4-40 P.M.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. ..... mos. 7 1-2 hours ds.

CONTRIBUTORY (Secondary) Premature delivery

(duration) 6 months mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phys signs

(Signed) Mrs Freeman, M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	8/22/24
20 UNDERTAKER	ADDRESS
George J Dalton	1735 Harford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Eks.

D 89657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 89657

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Smith

(a) Residence No. Home for the Aged of the M E church St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 27 1852

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS:

10-NAME OF FATHER Wm Schaffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Fulta

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Helen Bennett

(Address) 400 N Fulton Ave

15- Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

AUG 22 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 22-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1924 to Aug 22 1924 that I last saw her alive on Aug 21 1924 and that death occurred, on the date stated above, at 9:30a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ✓ yrs. ✓ mos. 2 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon M. D

Aug 22, 1924 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. Aug 23 1924

20-UNDERTAKER. George J Smith

ADDRESS 1513 Pennsylvania Ave

WHITE PENCIL, WITH UNFADING INK—THIS RECORD: Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89658

CERTIFICATE OF DEATH.

74 001 D 89658

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 E. Lanvale ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. J. Robinson

(a) RESIDENCE No 17 E. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Miriam J. Robinson

6 DATE OF BIRTH (month, day, and year) Feb. 16th 1850

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	74	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. J. Robinson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emily Buck

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Harold Robinson (Address) 17 E. Lanvale St.

15 Robert F. Harrison, ..., 19 ..... Registrar

Burial Permit Clerk

G 2 21924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1924

17

I HEREBY CERTIFY, That I attended deceased from May, 1923, to Aug. 22, 1924, that I last saw him alive on Aug. 22, 1924 and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis Endocarditis, Myocarditis

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Krachin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garner Family Cemetery DATE OF BURIAL Aug. 24, 1924

20 UNDERTAKER Fred'k Lassahn & Son ADDRESS Fullerton

GEN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89659

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Camel St. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Williams

(a) RESIDENCE. No. 312 Camel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leo Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cornelia Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Williams (Address) 312 Camel St

15 Filed ..... 19 Robert P. Harrison, Registrar

AUG 21 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/ 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19- 1924, to Aug 20, 1924, that I last saw h.e alive on Aug 20, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Psoas abcess Rt. & left sides.

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) — yrs. 2 mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Clinical exam.

(Signed) Chas. J Keller, M. D.

19 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 23 1924
20 UNDERTAKER Samuel T Hunsley	ADDRESS 518 N Bdle

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89660

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St. 2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Elizabeth Carroll

(a) Residence No..... Mount Hope Retreat St., 2 Ward St Mary's Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 38 yrs. 6 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 2 1886

7-AGE, 38 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town). St. Marys Co (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James H. Carroll

11-BIRTHPLACE OF FATHER (city or town) St. Marys Co. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary V. Davis.

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), Virginia

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Md.

15- Filed AUG 23 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24 - 24

17- I HEREBY CERTIFY, That I attended deceased from July 24th, 1924 to Aug 24, 1924, that I last saw h.. alive on Aug 24, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy -

(Duration) 20 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Epileptic Psychosis

(Duration) 20 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? St Marys Co Md -

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Aloysius - St Mary Co. Md. DATE OF BURIAL, Aug 26, 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Alexander

(a) Residence No. 556 W. Conway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown 1884

7-AGE. 30-40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) ? (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed AUG 23 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-21-24

17- I HEREBY CERTIFY, That I attended deceased from 8-19, 1924, to 8-21, 1924, that I last saw h[illegible] alive on 8-21, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(Duration) yrs. 9 mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Evans M. D.

8-21, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Aug. 23, 1924

20-UNDERTAKER, John H. Toadvine — ADDRESS 1027 Hendrickson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89662 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89662

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella May.

(a) RESIDENCE NO. 903 N. Calvert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. ---- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	----	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Music teacher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Dominic May.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Mills.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant J. Stuart Walter. (nephew)
(Address) 3910 Cloverhill Rd.

15 AUG 23 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Abobtexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Aug. 21, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 903 N. Calvert St. August 20, 1924

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mun. Cathedral Cem.	Aug 22 1924
20 UNDERTAKER	ADDRESS
F. A. Kramer & Son	1037 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39663

CERTIFICATE OF DEATH.

90 D 39663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Druid Hill Av ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Glenn

(a) RESIDENCE. No. 1728 Druid Hill Av ST., WARD.
(Usual place of abode.)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Glenn

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Frank Glenn (Address) 1728 Druid Hill Ave

15 Filed , 19 Registrar

AUG 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug - 4 - 24, to Aug. 21, 1924, that I last saw her alive on Aug 20, 1924 and that death occurred, on the date stated above, at 7:15 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6? mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. R. Hughes M.D.

Aug 21, 19 26 (Address) 1413 D. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem	Aug 23 1924

20 UNDERTAKER: Arnold Hawley ADDRESS: W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 89664

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 W. Franklin ST., 19 WARD)

2-FULL NAME Rosa Lena Banks

(a) RESIDENCE NO. 1622 W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	married

5a If married, widowed, or divorced (or) WIFE of Frank Banks

6 DATE OF BIRTH (month, day, and year) 8/28/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) Organist

(c) Name of employer (Church) Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Frances Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

14 Informant Mrs. Rosa Banks (Sister)

(Address) 1625 Druid

15 AUG 23 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1924

17

I HEREBY CERTIFY, That I attended deceased from 8/11, 1924, to 8/20, 1924, that I last saw h alive on 8/19, 1924, and that death occurred, on the date stated above, at 2:20 a m

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Contributory

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. T. Jackson, M. D.

8/21, 1924 (Address) 808 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Aug 23 24

UNDERTAKER Samuel K Hawley ADDRESS 1301 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 89665

D 89665 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Jos. Hospital Baltimore. Md.

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel W. Thompson

(a) RESIDENCE NO. Fallston Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Emma Parker

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
65 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Martha Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co Md

14 Informant Mrs S W Thompson
(Address) Fallston Md

15 Filed AUG 23 1924 H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to Aug 22nd, 1924, that I last saw him alive on Aug 22nd, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Injury from fall off wagon to abdomen resulting in Mysenteric Thrombosis of blood Vessels.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Fallston

Did an operation precede death? No Date of .....

Was there an autopsy? abdomen opened.

What test confirmed diagnosis?

(Signed) G. B. Seybert, M. D.

. 19 (Address) St Jos. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezar Church Cem	Aug 25 1924
20 UNDERTAKER	ADDRESS
E G Kurtz & Son	Jarrettsville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89666 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 89666

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Ellerslie Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James O'Connor

(a) RESIDENCE. No. 3106 Ellerslie Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Aug 21,1924.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work ------ dno

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Patrick O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant [signature illegible]
(Address) 2631 Mcalmont St

15 Filed AUG 23 1924 [signature illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.22,1924 19

17 I HEREBY CERTIFY, That I attended deceased from Aug.21,1924 19 to Aug.22,1924 19, that I last saw him alive on Aug.22,1924 19, and that death occurred, on the date stated above, at 8-15 P.M.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Premature delivery

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys.signs

(Signed) [signature illegible] M. D.

19 (Address) 2631 Mcalmont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 23 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hayford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89667

CERTIFICATE OF DEATH.

15 - 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1645 N Monroe St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen Elizabeth Jones

(a) Residence No. 1645 N Monroe St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 25 06

7-AGE, 18 yrs. 4 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....?.....

9-BIRTHPLACE (city or town) (State or Country). Indiana

PARENTS.

10-NAME OF FATHER, Charles Howard Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Nettie Bruskin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-

(Informant) B. H. Jones

(Address) 1645 N. Monroe

15-

Filed AUG 23 1924 G G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 20 1924

17- I HEREBY CERTIFY, That I attended deceased from April 20, 19 24 to August 20, 19 24

that I last saw h[illegible] alive on August 20, 19 24

and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Brown M.D. M. D.

(Address) 2 [illegible] Way Cor N M

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Aug 23, 19 24.

20-UNDERTAKER, H. M. Routson — ADDRESS 2258 N Paca

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89668

CERTIFICATE OF DEATH.

1468 D 89668

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jessie Campbell

(a) Residence No. 592 W. Biddle St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE,	If LESS than 1 day,
25-30 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) ? (State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND.

15- Filed ..... 192.. Registrar.

AUG 23 1924

1711

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8-20-2x

17- I HEREBY CERTIFY, That I attended deceased from 8-13, 19 2x to 8-20, 19 2x

that I last saw h[illegible] alive on 8-20, 19 2x

and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia (Postpartum)

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Drew M. D.

8-24, 192 4 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19....
20-UNDERTAKER, Commissioner of Health,	ADDRESS

Per. WM. S. WOODALL.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89669

CERTIFICATE OF DEATH.

D 89669

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3715 E. Balto St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine H. Hutton

(a) Residence No. 3715 E. Balto St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 28/24

7-AGE. yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. W. Hutton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Sylvia L. Bortner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Geo. W. Hutton

(Address) 103 Rochester Pl.

15- Filed AUG 23 1924 192 G G Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 22/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1924 to Aug. 22, 1924 that I last saw h. alive on Aug 22 1924 and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Dobihal M. D

, 19 (Address) 4474 N. Linwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn

DATE OF BURIAL. Aug 23 1924

20-UNDERTAKER. Philip Herwig

ADDRESS 3016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 39670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39670

CERTIFICATE OF DEATH.

REGISTERED NO. C 27 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5004 Augusta Ave Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs H. J. Hickey

(Residence in Baltimore: No. 5004 Augusta Ave Hamilton.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (~~Write~~ the word.)
M	W	Married

6-DATE OF BIRTH, April 30, 1844.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
80 yrs. 4 mos. 19 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Delaware.

PARENTS.

10-NAME OF FATHER, Don't Know.

11-BIRTHPLACE OF FATHER (State or Country), Delaware.

12-MAIDEN NAME OF MOTHER ~~Mary~~ E. don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James P. Hickey

(Address) 5004 Augusta Ave

15- AUG 24 1924 Robert P. Harrison,
Filed ..... 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924, to August 15 1924, that I saw h[illegible] alive on August 15 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dr L L Tordy

(Duration) yrs. mos. ds.

(Signed) per Gustave A. Graf M. D.

8/22, 1924. (Address) Overlea

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Pauls Cemetery Rock Hall	Aug. 24, 1924
20-UNDERTAKER Hickson & Stiles	ADDRESS 320 Md. Ave Westport

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39671

CERTIFICATE OF DEATH.

45 D 39671

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2923 Dillon St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Single

(a) Residence No. 2923 Dillon St., Ward 1st

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Single

6-DATE OF BIRTH (month, day and year) May 3-1851

7-AGE. 72 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED none

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) homework

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany. not known

12-MAIDEN NAME OF MOTHER, Elizabeth Lang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany not known

14-

(Informant) Lewis Single

(Address) 2923 Dillon st

15-

AUG 24 1924

Registrar.

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from about Jan 1 1924 to Aug 21 1924

that I last saw her alive on Aug 20 1924

and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma 4th Omentum

(Calcium)

(Duration) 1 + yrs. mos. ds.

CONTRIBUTORY (Secondary) exhaustion (etc)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/23, 1924 (Address) 1014 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	Aug 24, 1923
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

174127

Spec.—1-10-21—M&T—1500 Bks.

D 89672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 89672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Schaffer

(a) RESIDENCE NO. 703 E Dallas St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Nov 18, 1923

7 AGE — Years: — Months: 9 Days: 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto MD

PARENTS

10 NAME OF FATHER: Michael Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto MD

12 MAIDEN NAME OF MOTHER: Theresa Somerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto MD

14 Informant (Address): Johns Hopkins Hospital Broadway & Monument St

15 Filed . 19 Joseph F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 18 1924 to Aug 22 1924.

that I last saw him alive on Aug. 22 1924

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bagg, M. D.

. 19 Address: Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Stanislaus Cemetery — DATE OF BURIAL: Aug 25 1924

20 UNDERTAKER: H. Sander & Son — ADDRESS: 1700 Fleet St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39673 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 39673

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mount Hope Retreat St. 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Flaherty

(a) Residence No. Mt Hope Retreat St., 28 Ward Greenwich Conn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 9 ds. How long in U. S., If of foreign birth? 29 yrs. 0 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 30 1895

7-AGE, 28 yrs. 0 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman - 10

(b) General nature of industry, business, or establishment in which employed (or employer): Selling goods

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Greenwich Conn

PARENTS.

10-NAME OF FATHER, Patrick H. Flaherty

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cork Ireland

12-MAIDEN NAME OF MOTHER, Rose Ann McDonald

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Fermagh Ireland

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Baltimore Md

15- Filed Aug 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 23-24

17. I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1920, to Aug 23, 1924, that I last saw he alive on Aug 22, 1924, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chr. Pul - Tuberculosis

abt (Duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Paramount Tuberculosis

abt (Duration) 11 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Greenwich Conn

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Cannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenwich Conn — DATE OF BURIAL, Aug 26 1924

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 100 W. NORTH AVE.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 113

City of BALTIMORE: (No. 103 N. Fremont Ave St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Earl Wilt

(a) Residence No. 103 N. Fremont Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 29 1924

7-AGE, ... yrs. 4 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Guy Wilt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), W. Va

12-MAIDEN NAME OF MOTHER, Thelma Duvall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn.

14- (Informant) Guy Wilt

(Address) 103 N. Fremont Ave

15- Robert P. Harrison, Registrar.

G2 4 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 22-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1924, to Aug 22, 1924, that I last saw h. alive on Aug 22, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Harry Glassman, M. D.

Aug 23 1924 (Address) 1208 Mercantile Bk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Fredericksburg Va Aug 24, 1924

UNDERTAKER, Harry H. Witzke ADDRESS 1531 W Lombard St

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89675

CERTIFICATE OF DEATH.

X 161-006 D 89675

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Catherine Green

(a) RESIDENCE NO. Franklintown. Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 26/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Franklintown Md

PARENTS

10 NAME OF FATHER: William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ella McKoys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: William Green

(Address): Franklintown Md

15 AUG 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-9, 1924, to 8-23, 1924

that I last saw her alive on 8-23-@ 11 am, 1924,

and that death occurred, on the date stated above, at 11½ a m.

The CAUSE OF DEATH* was as follows:

Prematurity, Pemphigus.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

Life (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of .....

Was there an autopsy? None

What test confirmed diagnosis? Signs & Symptoms

(Signed) M Edwards M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D Kingsville Md — DATE OF BURIAL: Aug 23 1924

20 UNDERTAKER: David Dandeno — ADDRESS: Upper Falls Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89676

D 89676

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 E. Monument St., 10 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Glassman

(a) Residence No. 1312 E. Monument St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Glassman

6-DATE OF BIRTH (month, day and year)

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Juluis Kerwitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Jennie -------

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) J. Lewis

(Address) 1439 E. Balto. St.

15- Filed AUG 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 24-24

17- I HEREBY CERTIFY, That I attended deceased from Aug-19 19 24 to Aug. 24 19 24

that I last saw her alive on Aug. 23. 19 24

and that death occurred, on the date stated above, at 1.05A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis
+ Chr. Nephritis +
Arteriosclerosis.

(Duration) ----------

CONTRIBUTORY (Secondary) Uraemic Coma.

(Duration) 1 yrs. 1 mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine - Blood

(Signed) David Frankenthal M. D

8/24, 1924 (Address) 1224 N. Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mehrsam Bros & Co	8/27/24
20-UNDERTAKER,	ADDRESS
Jack Lewis	1439 E Balto

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 39677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39677

CERTIFICATE OF DEATH.

16-005

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 7 WARD)

2-FULL NAME Henry Gilmore

(a) RESIDENCE NO. 933 N Broadway ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 26-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Pearl Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother Pearl Coleman
(Address) 933 N Broadway

15 Filed AUG 4 1924, 19 .....

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 16 -, 1924, to Aug 22 -, 1924,

that I last saw h- alive on Aug 22 -, 1924,

and that death occurred, on the date stated above, at 12 P.M. m.

The CAUSE OF DEATH was as follows:

Dysentery (Flexner)

(duration) ..... yrs. ..... mos. 1st ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Chas. R. Bagg, M. D.

, 19 ..... Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 24 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725-Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 39678

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

100 D 39678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital.

CITY OF BALTIMORE: (No. Calvert & 33rd ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mack Cohen

(a) RESIDENCE NO. 2701 Wilkens Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Mrs Addie Cohen

6 DATE OF BIRTH (month, day, and year) May 5, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Morris Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Patient (Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

0624 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug. 23, 1924, that I last saw him alive on Aug 23, 1924, and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Staphlococcus Aureus Septicemia.

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Pneumonia?

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood Culture.

(Signed) by mail, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Rosedale Aug. 24 1924 — DATE OF BURIAL

20 UNDERTAKER Jos Leins ADDRESS 1439 E Balto

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89679

100-001

D 89679

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St & Patterson Park Ave ST., 6 WARD)

2-FULL NAME Mrs Fredas Lark

(a) RESIDENCE No. Hebrew Friendly Inn ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E Balto.

15 Filed AUG 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 24, 1924

that I last saw h alive on Aug 24, 1924

and that death occurred, on the date stated above, at 12:20 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Adler Consulting M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Rosedale Aug. 24, 1924

20 UNDERTAKER — ADDRESS

Jos Lewis, 1439 E. Balto

AUG. 24 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

Over

D 89680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. near Regis ave Wallis Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Madanick

(a) Residence No. Wallis Ave St., Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced.~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Meldow

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Home work.

(c) Name of employer City

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Aaron Fogelmanski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Saja ——

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Harry Madanick

(Address) 2423 N. Montford

15- Filed Aug 27 1924 Albert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23/24.

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 19 23 to Aug 23 19 24

that I last saw h.. alive on Aug 23/24 19.....

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

+ Lobar Pneumonia.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy + Pleural Adhesions

(Duration) yrs. mos. 16 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) A. W. Legg M. D

, 19 (Address) Park & Eight Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Road Washington Road	Aug 26 24

20-UNDERTAKER. ADDRESS

Jos. Lewis, 1439 E. Baltimore

UG 27 1924

WRITE IN PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89681

CERTIFICATE OF DEATH.

D 89681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Robert ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucie Savage

(a) RESIDENCE No. 502 Robert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	17	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Shirts 046

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Toby Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Savage (Address) 502 Robert St

15 Filed ....., 19.... Robert P. Harrison Registrar

AUG 24 1924

Daniel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1924

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to Aug 22, 1924, that I last saw her alive on Aug 22, 1924, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

8/23, 19 24 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Auburn Cemetery

DATE OF BURIAL Aug 25 19 24

20 UNDERTAKER Charles H. Alexander

ADDRESS 406 Druid Hill [redacted]

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Eks.

D 89682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89682

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2116 Cambridge St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Miller

(a) Residence No. 2116 Cambridge St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Miller

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant) Paul Miller

(Address) 2116 Cambridge St

15- (Filed) AUG 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1924 to Aug. 23, 1924 that I last saw h.. alive on Aug. 22, 1924 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (cerebral)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Kruger M. D

19 (Address) 2629 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, Aug 25, 1924

20-UNDERTAKER, Jas. E. Crockett — ADDRESS 1906 Bolton

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89683

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 801 D 89683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2034 Kennedy Ave ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Wahle

(a) RESIDENCE No 2034 Kennedy Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Richard Wahle

6 DATE OF BIRTH (month, day, and year): May 13 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	69	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Carl Shiller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Buenhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Richard Whale (Address) 2034 Kennedy Ave

15 AUG 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from August 22nd 1924, to August 25th 1924 that I last saw h[illegible] alive on Aug 25th 1924 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos 1 ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) ..... yrs. ..... mos. 12 hrs

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) P. E. Lilly, M. D.

Aug 24 1924 (Address) 501 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cremation DATE OF BURIAL Aug 25 1924

20 UNDERTAKER: A L Marshall ADDRESS 3539 Fall Rd

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89684

D 89684

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St., N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Benny - (Benny)

(a) RESIDENCE No. 3503 Leverton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	-	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm L. Benny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm L. Benny (Address) 3503 Leverton Ave

15 Filed AUG 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1924, to Aug. 22, 1924, that I last saw him alive on Aug 22, 1924, and that death occurred, on the date stated above, at 10 00 A m.

The CAUSE OF DEATH* was as follows:

Pleuritis Angina

Gastric Insufficiency

Hemorrhagic Pancreatitis, Bleeding from Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Aug. 20 24

Was there an autopsy? —

What test confirmed diagnosis? Wassermann Blood and Sputum Exam

(Signed) F. V. Bartalomeo M. D.

Aug 22. 1924 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 8/25 1924

20 UNDERTAKER Philip Herwig

ADDRESS 206 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89685 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89685

CERTIFICATE OF DEATH.

1113

1-PLACE OF DEATH

City of BALTIMORE: (No. 2102 Md. Ave St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean C. Cunningham

(a) Residence No. 2102 Md. Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Apr 23/23

7-AGE. 1 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) City
(State or Country),

PARENTS.

10-NAME OF FATHER, Robt. L. Cunningham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Pearl Blown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Robt. L. Cunningham

(Address) 2102 Md. Ave

15- Filed Aug 24 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 23/24

17- I HEREBY CERTIFY, That I attended deceased from August 16 19 24 to August 23 19 24

that I last saw her alive on August 23 19 24

and that death occurred, on the date stated above, at 10-P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

8/23 1924 (Signed) Doryn M. Fyffe M. D.
(Address) 1436 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL. Aug 25 1924

20-UNDERTAKER Philip Hemig — ADDRESS 3016 Orleans St

AUG 24 1924

WHITE PENCIL WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89686

CERTIFICATE OF DEATH.

10

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 w. Cross ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian D. Owens.

(a) RESIDENCE. No. 130 w. Cross ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 8. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.. Md.

PARENTS

10 NAME OF FATHER James H. Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Mary A. Kenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Jas. H. Owens
(Address) 130 W. Cross St.

15 Filed AUG 24 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 23. 1924

17 I HEREBY CERTIFY, That I attended deceased from 8. 21. 1924 to 8. 23. 1924 that I last saw her alive on August 23, 1924 and that death occurred, on the date stated above, at 2.45P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Lab. findings

8. 23. 1924 (Signed) J. Edward Norris, M. D.
(Address) 107 E. west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug. 24 1924
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 D 89687

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View, Baltimore 23 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Johnson

(a) Residence No. 10 N. Leadenhall St. Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced, Husband of ~~Wife~~ of William Johnson.

6-DATE OF BIRTH (month, day and year) 9 00

7-AGE. 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Robert Gross.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Clara Wells.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14- (Informant) Hospital Records. (Address) Bay View Hospital

15- Filed Robert P. Harrison, Registrar.

G 2 4 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8/21/24

17- I HEREBY CERTIFY, That I attended deceased from 8/19/24 to 8/21/1924 that I last saw h[e] alive on 8/21/1924 and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas (2 wk.).
Secondary Lues.
Pregnancy (Terminated 6 months)
Miscarriage (Duration) yrs. mos. ds.
Hot Streptococcal Septicemia (Strep.
(Secondary)
Haemolyticus (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab. Tests.

(Signed) Jas. P. Champe M. D.

(Address) Bay View Hospital. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Centreville Md	Aug 25 1924
20-UNDERTAKER.	ADDRESS
John H. Toadvine	Daniel Hill Md.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89688

CERTIFICATE OF DEATH.

+196

D 89688

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. In front of Pier 3 Locust Point St., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LeRoy G. Crum.

(a) RESIDENCE NO. Woodstock Maryland. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------.

6 DATE OF BIRTH (month, day, and year) April 10, 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Water boy
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Woodstock Md.

PARENTS

10 NAME OF FATHER: Frank L. Crum.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co. Md.

12 MAIDEN NAME OF MOTHER: Nona Baer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia.

14 Informant: Frank L. Crum. (father). (Address) Woodstock Md.

15 Filed AUG 24 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted.
Climbing an electric pole and
grabbing an exposed wire.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Aug. 24, 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount. Olivet Frederick Md

DATE OF BURIAL: Aug 27 1924

20 UNDERTAKER: Easton Sons

ADDRESS: Elliott Co

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89689

CERTIFICATE OF DEATH.

D 89689

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 S Kenwood Ave. WARD 1)

2-FULL NAME Wladyslawa Marecki

(a) RESIDENCE NO. 837 S Kenwood Ave ST., 1 WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House girl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Peter Marecki
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland
12 MAIDEN NAME OF MOTHER Stanislawa ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Marecki
(Address) 837 S Kenwood Ave

15 AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 1924, to 8/22, 1924, that I last saw her alive on 8/22, 1924, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Heart failure & asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Signs & symptoms

(Signed) Henry A Bulbose, M. D.

8/23, 1924 (Address) 1623 E Oath ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 25 1924
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	100 S Kenwood Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39690 ✓ 37 D 39690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Frost

(a) RESIDENCE NO. Frostburg Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work S-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Wm F Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Mary Baughman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother (Address) Abvs

15 Filed AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-24

17 I HEREBY CERTIFY, That I attended deceased from 8-20-24, 19, to 8-24-24, 19,

that I last saw him alive on 8-24-24,

and that death occurred, on the date stated above, at 12 30 pm.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis (1.15.9)

Cerebral Abscess.

(duration) yrs. 5 wks ds.

CONTRIBUTORY (Secondary) Septic Infection;

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sig is

(Signed) Jno A Lampkin M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run	Aug 27 1924
20 UNDERTAKER	ADDRESS
H Barnhart & Son	Westmnst

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2816 Parkwood Ave St. 13 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seymour Fahnestock

(a) Residence No. 2816 Parkwood Ave St., 13 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 73 yrs. 3 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) MARRIED

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Fahnestock

6-DATE OF BIRTH (month, day and year) May-26-1851

7-AGE, 73 yrs. 3 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jewlry Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Jewlry

(c) Name of employer Hennegen-Bates Co

9-BIRTHPLACE (city or town) Waynesboro (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Derrick Fahnestock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Susan Nuce

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna.

14- (Informant) Mrs Annie Fahnestock (Wife)

(Address) 2816 Parkwood Ave

15- Filed AUG 25 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 22-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 16 24, to Aug 22 24, that I last saw h[illegible] alive on Aug 22 24, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Sudden (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edmund Fahnestock, M. D.

, 19 (Address) 2731 Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Aug-25/24 19....

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WODDEN, Successor)

ADDRESS 108 W. NORTH AVE.

THIS IS A PERMANENT RECORD. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39692

CERTIFICATE OF DEATH.

#6

D 39692

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 Cottage ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Raisin Gemmill Skirven

(a) RESIDENCE. NO. 3900 Cottage ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Percy Skirven

6 DATE OF BIRTH (month, day, and year) Feb. 24 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James B. Gemmill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Margaret S. Raisin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Miss Sarah Gemmill 1626 K St Washn. D.C.

15 Filed AUG 25 1924 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1924, to Aug. 23, 1924, that I last saw her alive on Aug 23, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

THE CAUSE OF DEATH* was as follows:

General Carcinomatosis of Abdomen - Originating in Ovary

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date Aug 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson, M. D.

(Address) 3928 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Kent Co. Md.	Aug 26 1924

20 UNDERTAKER ADDRESS

John O. Whitehill Aug 26/24.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89693 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89693

164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 39 S. Fulton Avenue St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Harriet A. Hoffman-House

(a) Residence No. 39 S. Fulton Avenue St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. House

6-DATE OF BIRTH (month, day and year) Jan. 8, 1834

7-AGE, 90 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob V. Hoffman

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Amelia Locke Merriam

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) Emma House

(Address) 39 S. Fulton Avenue

15-

Filed AUG 25 1924, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 1919, 19..., to Aug 23, 19.24., that I last saw h.. alive on Aug 22, 19.24. A. and that death occurred, on the date stated above, at 12.35 m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Schaefer, M. D.

8-23, 1924 (Address) 53 S. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Olivet Cem	Aug 25, 1924
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Bolton St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3632 Frederick Ave St., 20 Ward) 8/29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ella Poellmann

(a) Residence No. 3632 Frederick Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE: Leonard A. Poellmann

6-DATE OF BIRTH (month, day and year): March 7 1853

7-AGE: 71 yrs. 5 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, professiou, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ohio Co Ohio

PARENTS.

10-NAME OF FATHER: Andrew Trust

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Miss Deckenbaugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-
(Informant): Mrs Koff
(Address): 3632 Frederick Ave

15-
Filed ..... 19.. .....
Registrar.

AUG 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 23 1924

17- I HEREBY CERTIFY, That I attended deceased from November 1st, 1923, to Aug 23rd, 1924, that I last saw h.. alive on Aug. 23, 1924, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows: NEPHRITIS
Chronic Paranephromatous Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Analysis

(Signed) Emanuel Lazarus, M. D.

, 19 (Address) 2937 W Cabert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Ave	Aug 25, 19 24
20-UNDERTAKER. Jos B Cook	ADDRESS 1003 W Balto

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Coleman

D 89695

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89695

CERTIFICATE OF DEATH.

5

9

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Eden St. ST., WARD)

2-FULL NAME Myrtle B. Coleman

(a) RESIDENCE NO. 612 N. Eden St. ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Mr. F. Coleman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Holiday

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mrs. E. Coleman
(Address) 612 N. Eden St.

15 Filed AUG 25 1924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Aug. 23, 1924 (Address) 280 Hamburg Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug. 25 1924
20 UNDERTAKER Wm. H. Locks	ADDRESS 1202 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 89696

1-PLACE OF DEATH Municipal Tuberculosis Hospital Registered No.

City of BALTIMORE: (No. Balto, Md St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Vogler

(a) Residence No. 617 N. Linwood Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Single Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 26, 1870

7-AGE, 53 yrs. 8 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Factory employee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nicholas Vogler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Brede

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Hospital Records

(Address)

15- Filed AUG 25 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 22 1924

17- I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to Aug. 22, 1924, that I last saw h alive on Aug 22, 1924, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Pleurisy

Renal Tuberculosis

Pott's Paraplegia yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted ? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. findings Autopsy

(Signed) James A. White M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mathews Cem. DATE OF BURIAL. Aug 25 1924

20-UNDERTAKER. H. Sander Sons ADDRESS 1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Thames ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence A. Nickel

(a) RESIDENCE No. 1700 Thames (Thames) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.
(State or country)

PARENTS

10 NAME OF FATHER William Nickel

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Augusta Irwin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs. Wm. Nickel.
(Address) 1700 Thames St.

15 AUG 25 1924 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1924, to Aug 23, 1924,

that I last saw him alive on Aug 23, 1924,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Marasmus,

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Epharanston

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Wade M. D.

19 (Address) 1118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Aug. 25 1924
20 UNDERTAKER M. J. Sadowski	ADDRESS 705 S Allen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39698 ✓ D 39698.

CERTIFICATE OF DEATH.

132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Whatcoat ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pearman

(a) RESIDENCE No. 1307 Whatcoat ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Eliza Jane Pearman

6 DATE OF BIRTH (month, day, and year) Jan 25 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	58	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermuda

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermuda

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant Eliza Jane Pearman
(Address) 1307 Whatcoat St

15 Filed AUG 25 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to Aug 25, 1924.

that I last saw h~~im~~ alive on Aug 21, 1924,

and that death occurred, on the date stated above, at 8:50 A. m.

The CAUSE OF DEATH* was as follows:

Calculus of kidney

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

8/25, 1924 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL MT Auburn

DATE OF BURIAL 8/15 '24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 529 Dolphin St., 17 Ward)

Registered No. 74-006

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Leopper

(a) Residence No. 529 Dolphin St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~Husband of~~ (or) ~~Wife of~~ Elizabeth Cooper

6-DATE OF BIRTH (month, day and year) July 11 1869

7-AGE, 55 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Easton Md

PARENTS.

10-NAME OF FATHER, Jacob Copper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sally Sullivan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Mrs. Isabella Cooper

(Address) 627 Dolphin St

15-

Filed AUG 25 1924 19

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 21/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 19 1924 to Aug 21, 1924

that I last saw him alive on Aug 21, 1924

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Wm. C. Wagner, M. D.

8/24, 1924 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL, 8/25/24

20-UNDERTAKER, Daniel Carlin — ADDRESS 916 Bond ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39700 ✓ D 39700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. 131

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Fagen.

(a) RESIDENCE NO. 1421 E Pratt St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asadore Fagan

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Chentkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Linda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ~~Hus~~ Jack Lewis

(Address) 1439 E. Baltimore St.

15 AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924, to Aug, 24, 1924, that I last saw her alive on Aug 24, 1924, and that death occurred, on the date stated above, at 11:55 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Pyelonephritis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Adler Stadtherr, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Aug. 25 1924

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take care CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 39701 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 39701

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3207 Barclay ST. 12 WARD)

2-FULL NAME Samuel Taylor

(a) RESIDENCE. No. 3207 Barclay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Louisa Morton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Job work

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alex Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louisa Morton (Address) 3207 Barclay St.

15 Filed AUG 25 1924 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-1-24, 19.., to Aug 23rd, 1924, that I last saw h[illegible] alive on Aug 22, 1924, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas A Carper, M. D.

. 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Pleasant Rest Lowes	8-26 1924

20 UNDERTAKER Helen G. Holland ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89702

CERTIFICATE OF DEATH.

179 D 89702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Nanticoke ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Turner

(a) RESIDENCE NO. 1113 Nanticoke ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel C. K. Turner.

6 DATE OF BIRTH (month, day, and year) Aug. 9. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont. Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Samuel C. K. Turner (Address) 1113 Nanticoke St.

15 AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1923 to Aug 23 1924 that I last saw h[illegible] alive on Aug 23 1924 and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH was as follows:

Ch Int Nephr.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) John C. Schwyzer M. D.

. 19 (Address) 1 New Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Aug 25 1924

20 UNDERTAKER Mrs Mrs. J. W. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89703 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89703

CERTIFICATE OF DEATH.

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 So. Gilmor ST., 19 WARD)

2-FULL NAME Oden A. Lowman

(a) RESIDENCE NO. Halethorpe, Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 52	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Lowman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Maria Doiney

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jr. Lowman
(Address) 132 So. Gilmor St.

AUG 25 1924

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.
(Coroner)

Aug 24 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 27 1924

20 UNDERTAKER James Dizmang Son — ADDRESS 1003 S Paca St

Spec.—1-10-21—M&T—1500 Bks.

D 39704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39704

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1424 N Lanvale ST., 16 WARD)

2-FULL NAME William M. Super

(a) RESIDENCE No. 1424 N Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 14th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of Industry, business, or establishment in which employed (or employer) Penn

(c) Name of employer Grain Elevators

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Super

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER H. A. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas D. Super

(Address) 2511 Madison St Edgewood MD

15 Date AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 1924 to Aug 23 1924, that I last saw him alive on Aug 22 1924, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

(Secondary) Generalized arterio-sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY Chr Myocardial insufficiency

(duration) yrs. mos. 3 wks

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) Carroll Lockard M. D.

Aug 25 1924 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Aug 26 1924

20 UNDERTAKER Henry W Jenkins Sons

ADDRESS McCulloh-Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89705

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 108. N. 39th ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Hermes Williams

(a) RESIDENCE. NO. 108. N. 39th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Williams

6 DATE OF BIRTH (month, day, and year) 27 May 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mason Locke Weems

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Matilda Sparrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A.Co. Md.

14 Informant Elizabeth Chew Williams

(Address) 108 E 39th St

15 [illegible] 19

Registrar

AUG 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1916, to Aug 24, 1924, that I last saw her alive on August 24, 1924, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles Reid Edmunds M. D.

8/24, 1924 (Address) 214 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 26 1924
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Son Co	McCulloh & Orchard

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Walker ST., 7 WARD)

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguite Butler

(a) RESIDENCE NO. 1611 Walker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
apperot 5-8	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Morals Butler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Washington (sister) (Address) 1611 Walker st

15 Filed AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Aug 22, 1924, that I last saw h alive on ....., 19....; and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Entestinal

(duration) 4wks yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Cumming, M. D.

8/25 1924 (Address) 1420 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — UNDERTAKER

DATE OF BURIAL Aug 25 1924

ADDRESS

Jos. J. H. Rochester 1413 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89707 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89707

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a)

2-FULL NAME Fannie L. Hall

(a) RESIDENCE NO. 817 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hall

6 DATE OF BIRTH (month, day, and year) May 3, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John R. Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa Seals

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Mrs. Lewis
(Address) 1130 Stricker

Rec'd AUG 25 1924 H.M.W. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Incomplete abortion (duration) yrs. mos. ds.

(Signed) Dr. Greenwood, M. D. (Coroner.)

Aug 25, 1924 (Address) 202 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery DATE OF BURIAL 8-25-1924

20 UNDERTAKER Jno. M. Johnson ADDRESS 1309 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89708

HEALTH DEPARTMENT—CITY OF BALTIMORE

164

D 89708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 952 N. Eden ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis L. Hallameyer

(a) RESIDENCE NO. 952 N. Eden ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? 76 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary A. Hallameyer

6 DATE OF BIRTH (month, day, and year) Nov. 9 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Hallameyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie M. Kautz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. George F. Hallameyer

(Address) 952 N. Eden St

15 Filed AUG 25 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1924, to Aug. 24. 1924, that I last saw him alive on Aug. 24. 1924, and that death occurred, on the date stated above, at 1.45 A. M.

The CAUSE OF DEATH* was as follows:

Senile Exhaustion

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Old age (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Senile Weakness

(Signed) F. J. Sebald, M. D.

, 19 (Address) 1001 Arlington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 28 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1309 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1006 Bks.

D 89709 ✓ D 89709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Arlington ave St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Martin

(a) RESIDENCE. No. 908 N. Arlington Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31, 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Ezekiel Jones

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Bagdel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant T. Elizabeth Martin

(Address) 4126 Forest Park Ave

AUG 25 1924

Registrar H. Abbe

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17

I HEREBY CERTIFY, That I attended deceased frum May 1 1924, to Aug. 23, 1924, that I last saw h alive on Aug. 23, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray & Physical

(Signed) Robert C. Blake, M. D.

, 19 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 25 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 89710

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 S. Schroeder St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Richard Burry

(a) Residence No. 105 S. Schroeder St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louise Burry

6-DATE OF BIRTH (month, day and year) July 2, 1864

7-AGE. 60 yrs. 1 mos. 21 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jewelery Bus.

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS:

10-NAME OF FATHER, Joseph Burry

11-BIRTHPLACE OF FATHER (city or town) Alsace-Lorraine
(State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Rulland

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14- (Informant) William N. Burry

(Address) S. Stratford Apts. Liberty St.

15-

Filed ..... 192.....

AUG 25 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23 1924

17- I HEREBY CERTIFY, That I attended deceased from August 17, 1924 to August 23, 1924

that I last saw h.. alive on August 22 1924

and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows: Gangrene of prostate extending to the abdomen

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis & arteriosclerosis (Duration) over 1 year ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Test

(Signed) Harry E. Obrien M. D

8-23, 1924 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Nat'l Cathedral | DATE OF BURIAL: Aug 26 1924

20-UNDERTAKER. Wm Tickner & Sons | ADDRESS Norch & Pa

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8971F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8971F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. 41 W. West St., 23 Ward) Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Dorns

(a) Residence No. 41 W. West St., 23 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Dorns

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Solomon Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-

(Informant) Wm H. Dorns

(Address) 41 W. West St.

15-FILED AUG 25 1924

H. A. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/20/24

I HEREBY CERTIFY, That I attended deceased from June 5th '24 to 8/20/24

that I last saw h alive on 8/19/24

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis - other cause unknown,

(Duration) about 3 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Exam

(Signed) [illegible] M. D.

, 19 (Address) 1058 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, National Cem. DATE OF BURIAL, Aug 25, 19 24

20-UNDERTAKER, Samuel Hawley ADDRESS 1128 Pine

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Stanislaus. Grochowina

D 89712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89712

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 S. Peterson Pkwy ST., 1 WARD)

2-FULL NAME Stanislaw Grochowina

(a) RESIDENCE NO. 605 S. Peterson Pkwy ST., 1 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 10-14-23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michal Grochowina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kinka Zook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Grochowina
(Address) 605 S. Peterson Pkwy

15 AUG 25 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24- 1924

17

I HEREBY CERTIFY, That I attended deceased from August 17. 1924, to August 23. 1924, that I last saw him alive on August 23. 1924, and that death occurred, on the date stated above, at 3-30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at place of Death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Dr. Dominick

(Signed) H. Swarbrick Jr. M. D.

8-24- 1924 (Address) 732 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus

DATE OF BURIAL Aug. 25 1924

20 UNDERTAKER John A Weber

ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 89713 ✓ D 89713

D 89713 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Shell Road & 34 Street St., 26 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalia Anna. Smialek

(a) Residence No. Shell Road & 34 Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): April 5 1924

7-AGE: ....yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore
(State or Country): Md.

PARENTS

10-NAME OF FATHER: Frank . Smialek

11-BIRTHPLACE OF FATHER (city or town): Poland
(State or Country):

12-MAIDEN NAME OF MOTHER: Mary. Leczek

13-BIRTHPLACE OF MOTHER (city or town): Poland
(State or Country):

14- (Informant): Mr. Frank. Smialek
(Address): Shell Road &34 Street

15- Filed AUG 25 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 24. 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 19 24 to Aug 24 19 24

that I last saw h.. alive on Aug 24 19 24

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Lesion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Grauek M D

19 24 (Address) 801 Pennsylvania Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL, Aug. 25 19 24

20-UNDERTAKER: John F Weber — ADDRESS 1803 Bank st

NO. 2. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 S Sixth St., 26 Ward)

Registered No. 159

2-FULL NAME David John Hiltz

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 309 S Sixth St., 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 15th 1924

7-AGE. ..... yrs. 2 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Hiltz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Minnie Yeager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-

(Informant) John Hiltz

(Address) 309 S. Sixth St

15-

AUG 25 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23rd 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1924 to Aug 23 1924

that I last saw h.. alive on Aug 23 1924

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Unusual Convulsions

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Influenza Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright S Fiddes M. D

8-27 1924 (Address) 3323 E Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Dall Lawn Cem	Aug 25th
20-UNDERTAKER, Lilly & Geiler	ADDRESS 4033 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89715

D 89715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Burke

(a) RESIDENCE No. 1305 Hanbert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		6½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Richard Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Eliz McShell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Richard Johns Hopkins Hosp

15 Filed AUG 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 21 - 1924, to Aug 23 - 1924, that I last saw ~~him~~ alive on Aug 23 - 1924, and that death occurred, on the date stated above, at 10 25 m.

The CAUSE OF DEATH* was as follows:

Dysentery (Unidentified)

(duration) yrs. mos. 4 0 ds.

CONTRIBUTORY (Secondary) Marasmus, Tuberculosis

(duration) yrs. mos. 1 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Only Clinical findings

(Signed) Thos. K. Cobmoll, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Md.) DATE OF BURIAL Aug 25 1924

20 UNDERTAKER Margaret G. Flynn ADDRESS 14 W Preston St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89716

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Corner of Creek & Patterson ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Rosenblum

(a) RESIDENCE NO. 1323 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER L. Rosenblum

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Adler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mary L. Rosenblum
(Address) 1323 Broadway

15 Filed Aug 25, 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental
Drowning

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

(Signed) John Morrison, M. D.
(Coroner.)

(Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 25 1924
20 UNDERTAKER Robt P Turner & Son	ADDRESS 1422 Broadway

G 25 1924

Burial Permit Clerk

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Arthur 14269 Female

D 89717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H5D 89717

1-PLACE OF DEATH

City of BALTIMORE: (No. 1930 Edmondson ave. Ward 16)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... James M Coale

(a) Residence No. 1930 Edmondson ave. St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of late Emma W. Coale

6-DATE OF BIRTH (month, day and year) July 16/1856

7-AGE, 68 yrs. 1 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Balto

(b) General nature of industry, business, or establishment in which employed (or employer)..... City Police office 861

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Coale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Evans

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs J. Suter

(Address) 1920 Edmondson ave

15- Filed AUG 25 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24/1924

17- I HEREBY CERTIFY, That I attended deceased from January 17, 1924 to August 24, 1924 that I last saw him alive on August 23, 1924 and that death occurred, on the date stated above, at 530 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

Indefinite (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Indefinite

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? - X Ray -

(Signed) Harry S. Arthur, M. D.

, 19 (Address) 1426 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park	8/26, 1924

20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson

Burial Permit Clerk

I.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89718

HEALTH DEPARTMENT—CITY OF BALTIMORE

B9718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 743 Linnard St. 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Sophia Warnken

(a) Residence No. 1121 Ward St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Widow of John Fortune Warnken

6-DATE OF BIRTH (month, day and year) Dec 28/1854

7-AGE, 69 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER Christopher Berlinske

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mattie Krahs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Chas R. Warnken

(Address) 743 Linnard St

15- Filed AUG 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 22/1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to August 22, 1924, that I last saw h[er] alive on August 22, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) — yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteria-sclerosis and myocarditis (Duration) — yrs. over 3 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Henry C. Ohle, M. D.

8-23, 1924 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL, 8/25, 1924

20-UNDERTAKER. Geo. W. Boyd & Son — ADDRESS 2503 E. Monument

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-1-2001 D 89719

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 110. W. 23rd ST., 12 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Ruth

(a) RESIDENCE NO. 110. W. 23rd ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): June 16/22

7 AGE: Years 2; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greenwood S.C.

PARENTS

10 NAME OF FATHER: F. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER: Ada Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Ada Ruth
(Address): 110. W. 23rd St.

15 Filed ..... 192 ..... Robert P. Harrison, Registrar

1714

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to No natural death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Morrison (Coroner.), M. D.

Aug 24, 1924 (Address) 3632 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 192..

20 UNDERTAKER

ADDRESS

Commissioner Health,

UNIVERSITY OF MARYLAND

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003
159 D 89720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Shields al St 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Randall

(a) RESIDENCE NO. 1210 Shields alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. 5 How long in U. S., if of foreign birth? yrs. mos. 5 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-19-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George W. Sours

11 BIRTHPLACE OF FATHER (city or town) (State or country) York, Penn

12 MAIDEN NAME OF MOTHER Marie Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Princess Anne Co Md.

14 Informant (Address) Mother 1210 Shields Alley

15 Filed AUG 25 1924 19 Registrar Robert T. Harrison, 1715 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1924, to August. 24, 1924.

that I last saw him alive on Aug. 23, 1924,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: 8-24-24

Spina Bifida - Congenital

Mine Death (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septic Meningitis - (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms -

(Signed) D. Allen Fields, M. D.

Oct 23 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Dept. of Public Health

AUG 25 1924

Dept. Vital Statistics

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89721

CERTIFICATE OF DEATH.

REGISTERED No. 159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 Francis St. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Emma Lawrence

(a) RESIDENCE. No. 2510 Francis St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry C. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER Jane V. Greenup

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md,

14 Informant H. C. Lawrence
(Address) 2510 Francis St.

15 Filed AUG 25 1924 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Aug 24, 1924, that I last saw h.r alive on Aug 24, 1924, and that death occurred, on the date stated above, at 9.20 m.

The CAUSE OF DEATH* was as follows:

Patient Frozen dead

9 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (4½ months)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. T. Hennessy, M. D.

(Address) 2510 Kennedon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health,

AUG 25 1924

Burial 1716.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89722

D 89722

CERTIFICATE OF DEATH.

+ 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bowdy

(a) RESIDENCE NO. Port Antonio Brit. West Indies

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): British West Indies

PARENTS

10 NAME OF FATHER: James Bowdy

11 BIRTHPLACE OF FATHER (city or town) (State or country): British W. Indies

12 MAIDEN NAME OF MOTHER: Agnes Hardin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): British W. Indies

14 Informant: James Bowdy.

(Address)

15 7 5 1924 Robert F. Harrison, .19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-23-24

17

I HEREBY CERTIFY, That I attended deceased from 7-2-24, 19 , to 5-23-24, 19 .

that I last saw him alive on 5-23-24,

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH was as follows:

Pneumonia with Effusion

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Pericarditis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: 5-25-1924, 19

20 UNDERTAKER

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 39723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39723

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2231 Madison Ave WARD)

2-FULL NAME Mina Cohn

(a) RESIDENCE. No. 2231 Madison St. Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias Cohn

6 DATE OF BIRTH (month, day, and year) July 5, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	77	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mendel Mendel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. Cohn (Address) 2231 Madison Ave

15 Aug 25 1924 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1924, to Aug 24, 1924, that I last saw her alive on Aug 23, 1924, and that death occurred, on the date stated above, at 4.45a. m.

The CAUSE OF DEATH* was as follows:

Dermatitis Herpetiformis

Myocardial Degeneration

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leon Ginsburg, M. D.

Aug 24, 1924 (Address) 1406 Wickes Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	8/26/1924
20 UNDERTAKER	ADDRESS
David Sondheim	118 W. Mt. Royal Ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89724

CERTIFICATE OF DEATH.

1444

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2202 Eutaw Place St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Benjamin Bloch

(a) Residence No..... 2202 E. P ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Bloch

6-DATE OF BIRTH (month, day and year) June 7/1861

7-AGE. 63 yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Clothing

(c) Name of employer..... Gentleman

9-BIRTHPLACE (city or town) (State or Country). France

PARENTS.

10-NAME OF FATHER. Moses Bloch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). France

12-MAIDEN NAME OF MOTHER. Minnette Gutman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant)..... Mrs Bloch

(Address)..... 2202 Eutaw Place

15- Filed ..... Robert P. Harrison, Registrar.

AUG 25 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924 to Aug 24 1924 that I last saw h-im alive on Aug 24 1924 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical and operation

(Signed) Bury's No address M. D.

, 19 (Address) 2306 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Chet Shalom	Aug 26th 1924
20-UNDERTAKER.	ADDRESS
Hart & Goodheim	1126 W. Mt Royal Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89725

CERTIFICATE OF DEATH.

D 89725

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Murphy

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Sing

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Municipal Hospital Records

(Address)

15-

Filed 192 Robert P. Harrison Registrar.

AUG 25 1924

Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-18-24

17- I HEREBY CERTIFY, That I attended deceased from 7-31, 1924 to 8-18, 1924

that I last saw h— alive on 8-18, 1924

and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab + autopsy

(Signed) Claude S. Knox, M. D.

8-21, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Sacred Heart	8/25, 1924
20-UNDERTAKER.	ADDRESS
J. J. Bakey & Sons	1316 Eutaw St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 39726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39726

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Patapsco ST. 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Hoffman

(a) RESIDENCE. No. 1720 Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Hoffman

6 DATE OF BIRTH (month, day, and year) Dec 6 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nicholas Dennisl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mr John D Hoffman

(Address) 1726 Patapsco St.

AUG 25 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to Aug 23, 1924

that I last saw her alive on Aug 23, 1924

and that death occurred, on the date stated above, at 11-30 A. m.

The CAUSE OF DEATH* was as follows:

Inflammation of old age

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. B. F. Campbell M. D.

Aug 24, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	8/25/24
20 UNDERTAKER J. J. Baker & Sons	ADDRESS 1318 Light

INK.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Herbek)

D 89727

HEALTH DEPARTMENT—CITY OF BALTIMORE

74046

D 89727

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Herbek

(a) RESIDENCE NO. 730 Ramsay St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Herbek

6 DATE OF BIRTH (month, day, and year): Sept 23 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Jacob Herbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Frances Schenflock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Records

(Address): Here

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk

AUG 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 14 ....., 1924, to Aug 24 - ....., 1924,

that I last saw him alive on Aug 24 - ....., 1924,

and that death occurred, on the date stated above, at 3 15 - P. m.

The CAUSE OF DEATH* was as follows:

Primary Pernicious Hypertrophy

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, Cystoscopy

(Signed) Albert Wm Mackey, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill Cem.

DATE OF BURIAL: Aug 27 1924

20 UNDERTAKER: Zurkler & Zurkler

ADDRESS 1739 Eagan

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS AND OTHERS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89728

CERTIFICATE OF DEATH.

14001 D 89728

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1833 E. Eager St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adaline Meyers

(a) Residence No. 1833 E. Eager St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Roger Meyers

6-DATE OF BIRTH (month, day and year) June 13, 1846

7-AGE. 78 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Bertha Waldram

(Address) 1831 E. Eager St

15- AUG 25 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 22, 1924, to Saturday 23 1924, that I last saw h[illegible] alive on Aug. 23, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Hemorhag[illegible] of Brain (Cerebral Hemhage)

an Paralysis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemorhag[illegible] of Brain

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at 1833 E Eager

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas J. Symms, M. D.

, 19 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
Holy Redeemer	Aug 26, 24
20-UNDERTAKER. Jenkins & Jenkins	ADDRESS 1737 Eager St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89720

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 N Durham St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kennith L Knight

(a) Residence No. 1717 N Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 9th

7-AGE. ..... yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER Charles Knight

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Evelyn Maguire

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14-(Informant)..... Charles Knight
(Address)..... 1717 N Durham

15-Filed AUG 25 1924, 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 25th

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 19 24 to Aug 25 19 24

that I last saw h.. alive on Aug 25 19 24

and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frohna M. D

8 25, 1924 (Address) 1823 N Howard St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Aug 26, 1924

20-UNDERTAKER Wm Cook ADDRESS 502 North Ave

WRITE PLAINLY, WITH UNFADING INK. NAMES should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 89730

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 89730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 665 W Fayette ST.; 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis E. Miller

(a) RESIDENCE. No. 665 W Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina P. Miller

6 DATE OF BIRTH (month, day, and year) Dec 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: artificial wool dyer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Frederick Md.

PARENTS

10 NAME OF FATHER Fred Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs N.P. Miller 665 W Fayette

15 Filed AUG 25 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to Aug 23, 1924

that I last saw h alive on Aug 22, 1924

and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R.L. Campbell M. D.

8/24/24 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 26 1924
20 UNDERTAKER: W.M. Cook	ADDRESS: 502 E Fort Ave

AUG 25 1924

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 89731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 N Pat-Park Ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia C. Brandt

(a) Residence No. 903 N. Pat-Park Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Brandt

6-DATE OF BIRTH (month, day and year) Feb. 5, 1850

7-AGE. 74 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Chas F. Thurmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea Kumm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Pauletta Wolfe

(Address) 903 N. Pat-Park Ave

15- Filed AUG 25 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-25-24

17- I HEREBY CERTIFY, That I attended deceased from 8-10 1924 to 8-25 1924 that I last saw h.. alive on 8-24-24 and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Acute Nephritis
Hypostatic Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Lundeng M. D.

8-25 1924 (Address) 903 N Pat-Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel DATE OF BURIAL. Aug. 27, 1924

20-UNDERTAKER. Wm Corle ADDRESS 502 Edmondson

A B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89732

CERTIFICATE OF DEATH.

D 89732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Melrose Ave. Colgate WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith E. Schlimme

(Residence in Baltimore: No. Melrose Ave. Colgate St.; 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, July 11, (Month) (Day) 1866 (Year)

7-AGE, 57 yrs. 7 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work H.W.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Anne Arundel Co. Md

PARENTS.

10-NAME OF FATHER, Stephen Gray

11-BIRTHPLACE OF FATHER (State or Country) Anne Arundel Co. Md

12-MAIDEN NAME OF MOTHER Mary E. Connelly

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Schlimme

(Address) 4 Melrose Ave Colgate Md

15-

Filed Aug 25 1924 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 31st 1924, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1924, to Aug 31 1924, that I saw h[illegible] alive on Aug 23 1924, and that death occurred, on the date stated above, at 10 45 AM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Theodore A. Brown M. D.

8-31 1924 (Address) 913 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Aug. 26., 1924.

20-UNDERTAKER John F Penny — ADDRESS, 715 Light St

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89733 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Miss Margaret J. Callaghan

(a) Residence No.. 91 Washington St (Usual place of abode) Brighton, Mass Ward.....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1860.

7-AGE. 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Chiropodist.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Callahan ~~do not know~~

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Ireland ~~do not know~~

12-MAIDEN NAME OF MOTHER, do not know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland ~~do not know~~

14- (Informant) Margaret M Sweeney

(Address) 774 Huntington Ave.

15- Doctor Moore

16- Robert P. Harrison Registrar.

AUG 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/22/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1924 to Aug 22, 1924, that I last saw h.. alive on 8/22 1924, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Post Operative

Embolism

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer Cervix

(Duration)..... yrs. 4 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 8/7/24

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) John B. E. Keegan M. D

. 19 (Address) 904 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem Baltimore Md

DATE OF BURIAL. Aug 25 1924

20-UNDERTAKER. M Fahey Sons.

ADDRESS 1827 W North Ave

WHITE—PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary, Baltimore Md REGISTERED NO. 1390

CITY OF BALTIMORE: (No. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jennie Banks.

(a) RESIDENCE NO. 1623 St. Paul St. Baltimore Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Charles Banks

6 DATE OF BIRTH (month, day, and year) unknown 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jennie Kilduff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. K. Banks

(Address) 1623 St. Paul St

15 Aug 25 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Aug 27, 1924, that I last saw her alive on Aug 27, 1924, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Myofibromata of Uterus

Pelvic inflammatory disease

(duration) not known yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1623 St. Paul St. city

Did an operation precede death? Yes Date of Aug 23, '24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. C. Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 27 1924
20 UNDERTAKER	ADDRESS
E. A. Windsor Jr	501 E 22 St

AUG 25 1924

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~B~~ 89735

74 B 39735

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 E. 21st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Atlee

(a) RESIDENCE. No. 503 E. 21st ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 6th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: James Atlee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Sarah S Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co

14 Informant: Emma Coughlan

(Address) 503 E 21st St

15 Filed: Robert P. Harrison, Registrar

AUG 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug ~~23~~ 15th 1924. to Aug 23, 1924.

that I last saw her alive on Aug 23, 1924,

and that death occurred, on the date stated above, at 7 30 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Hemiplegia (Right side)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald T. Tonsy, M. D.

, 19 (Address) 414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Cathedral	Aug 26 1924
20 UNDERTAKER	ADDRESS
E A Woodfield Jr	501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 89736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89736

CERTIFICATE OF DEATH.

90

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3519 Cedar Avenue St. 13 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William H. Chenowith

(Residence in Baltimore: No. 3519 Cedar Avenue St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, December 2 (Month), 1849 (Day) (Year)

7-AGE, 75 yrs. 8 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Baltimore County Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary J. Chenowith

(Address) 3519 Cedar

15- Robert P. Harrison, 191

Registrar.

Burial Permit Clerk.

AUG 25 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Morris M. D.
(Coroner.)

Aug 25, 1924 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Aug. 26, 1924

20-UNDERTAKER E. LeRoy Steffey

ADDRESS 125 E. North Ave

Cor.—1-12-23—M&T—100 Bks.

D 89737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89737

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 E. 33rd St. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav C. Otto.

(a) RESIDENCE NO. 718 E. 33rd St. ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine O. Otto.

6 DATE OF BIRTH (month, day, and year) Dec 11-1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Paul. Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E. Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address)

15 Filed Aug 25 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Tuberculosis of Larynx

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison (Coroner) M. D.

Aug 25, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 26 1924

20 UNDERTAKER F. B. Hilliard ADDRESS 1850 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

1101 N Fulton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39738

CERTIFICATE OF DEATH.

129 D 39738

1-PLACE OF DEATH

City of BALTIMORE: (No. 1832 W. Pratt St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Elvin Jones

(a) Residence No. 1832 W. Pratt St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Jones

6-DATE OF BIRTH (month, day and year) May 15th 1862

7-AGE 62 yrs. 3 mos. 8 ds. | If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of Industry, business, or establishment in which employed (or employer) =

(c) Name of employer

9-BIRTHPLACE (city or town) Dorchester Co.
(State or Country) Md.

PARENTS:

10-NAME OF FATHER Capt Thos Jones

11-BIRTHPLACE OF FATHER (city or town) Dorchester Co.
(State or Country) Md.

12-MAIDEN NAME OF MOTHER Isabella Towell

13-BIRTHPLACE OF MOTHER (city or town) Dorchester Co.
(State or Country) Md.

14- (Informant) Elizabeth Jones

(Address) 1832 W. Pratt St

15- Filed AUG 25 1924 192... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 3, 1924, to Aug 23, 1924

that I last saw him alive on Aug 23, 1924

and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary etc

(Signed) Chas. C. Conser M. D.

8-25-24 (Address) 1101 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery | DATE OF BURIAL: Aug 26th 19 24

20-UNDERTAKER: F. A. Heppe | ADDRESS: 1850 N. Gallo St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89739

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 S High St St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Chayett

(a) Residence No. 117 S High st St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) —

7-AGE. 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Luther Chayett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Mary Chayett

(Address) 117 S. High st

15-

AUG 26 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8/25/24

17- I HEREBY CERTIFY, That I attended deceased from May Aug 22, 1924, to Aug 25, 1924,

that I last saw h.. alive on Aug 25, 1924

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Liver

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? History + Phys. Exam

(Signed) Jarold Custer M. D.

8-26, 1924 (Address) 223 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Hamingfield

DATE OF BURIAL. 8/26, 1924

20-UNDERTAKER. A. Lennon & Bro

ADDRESS 112 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS RECORD MUST BE FILLED OUT EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89740

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Callow Ave ST., 13 WARD)

2-FULL NAME Harry M Swartz

(a) RESIDENCE No. 2116 Callow ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ adeline Swartz

6 DATE OF BIRTH (month, day, and year) June

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer

9 BIRTHPLACE (city or town) Newark
(State or country)

PARENTS

10 NAME OF FATHER Joseph Swartz

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Kaufman

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Adline Swartz
(Address) 2116 Callow Ave

15 AUG 26 1924 H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1924, to Aug. 24th 1924 that I last saw him alive on Aug 23rd 1924 and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Hunter M. D.

, 19 (Address) 2302 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harlem Friendship

DATE OF BURIAL Aug 26 1924

20 UNDERTAKER J. Ahrens & Co

ADDRESS 100 Mad Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

D 89741

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 89741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 606 W Conway St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dennis

(a) Residence No. 606 W. Conway St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Dennis

6-DATE OF BIRTH (month, day and year) Dec 1874

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Reynolds

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Alethia Hooks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Wm Dennis

(Address) 606 W Conway St.

15- Filed AUG 26 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/23/24

17- I HEREBY CERTIFY, That I attended deceased from 8/15/24 to 8/23/24 that I last saw h.. alive on 8/27/24 and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Finley Bowley, M. D.

8th, 1924 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 8/26/24

20-UNDERTAKER David Easton

ADDRESS 976 Ba ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89742

HEALTH DEPARTMENT—CITY OF BALTIMORE

89742

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 12 WARD)

2-FULL NAME Mr. Charles R. Leight.

(a) RESIDENCE NO. 2645 Francis ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Fowble Leight

6 DATE OF BIRTH (month, day, and year) April 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 1876

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Leight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Sallie Earhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mr. Chas. R. Leight
(Address) 2645 Francis St.

15 Filed AUG 25 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-1924

17 I HEREBY CERTIFY, That I attended deceased from 8-18-, 1924 to 8-26-, 1924, that I last saw him alive on 8-26-, 1924, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate - 1 year
Suppurative Nephritis } (?) Months
Suppurative Cystitis }
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Templeton, M. D.

, 19 (Address) M. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emory Chapel Cemetery Md. DATE OF BURIAL Aug 28 1924

20 UNDERTAKER Wm. Luckner & Son ADDRESS N. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1263 Sargeant ST., 21 WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew R Baker

(a) RESIDENCE NO. 1263 Sargeant ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles J. Baker

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah M. Buchanan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Charles J. Baker
(Address) 1263 Sargeant St.

AUG 26 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 8/15/24, 19..., to 8/25/, 1924.

That I last saw h.. alive on 8/25/, 1924,

and that death occurred, on the date stated above, at 3:10 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(duration) yrs. mos 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Aug 28 19 24
20 UNDERTAKER Geo. Lumback & Son.	ADDRESS 647 W. Pratt St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89744

D 89744 HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sheling Sanitorium

CITY OF BALTIMORE: (No. Norwood Hghts nr Catonsville ST. 29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassie P. Barnett

(a) RESIDENCE. No. 1408 Hollins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Barnett

6 DATE OF BIRTH (month, day, and year) April 30-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie J. Partridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant James Barnett

(Address) 1408 Hollins St

AUG 26 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23 1924

17 I HEREBY CERTIFY, That I attended deceased from August 19, 1924, to August 23, 1924, that I last saw h[illegible] alive on August 19, 1924, and that death occurred, on the date stated above, at 11m P. m.

The CAUSE OF DEATH* was as follows:

Cardio Respiratory Paralysis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. 5yr ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Linton Cliff M. D.

8/25, 1924 (Address) 312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 8-26 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Catonsville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 543 N. Washington St., 7 Ward)

Registered No. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Heller

(a) Residence No. 543 N. Washington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Heller.

6-DATE OF BIRTH (month, day and year) Sept 13, 1864

7-AGE. 60 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman 1926

(b) General nature of industry, business, or establishment in which employed (or employer) Iron foundry

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Casper Heller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna R. Hebbs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs. Anna C. Heller

(Address) 543 N. Washington St

15- AUG 26 1924 H. Anne. Registrar.

MEDICAL CERTIFICATE OF DEATH. Aug 24/1924

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Aug 24, 1924, that I last saw him alive on Aug 24, 1924, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart-Compensated

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard C. Sellers, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cemetery — DATE OF BURIAL, Aug 27, 1924

20-UNDERTAKER. John Ulrich — ADDRESS 2008 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK AND PEN. Every question should be carefully answered EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Note instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 89746 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89746

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 S. Ann St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Walston

(a) Residence No. 327 S. Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Walston

6-DATE OF BIRTH (month, day and year) Don't know

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Fairmont Co Md

PARENTS.

10-NAME OF FATHER, James E Walston

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sallie Kent

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Mrs Alexis Ford

(Address) 447 N Milton Ave

13- Aug 26 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 25-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 19 24 to Aug 25 19 24

that I last saw him alive on August 24 19 24

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

13-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo Keller M. D.

1925 (Address) 937 Gough St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Fairmount Maryland	Aug 27 1924
20-UNDERTAKER, John Ulrich	ADDRESS 2005 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89747 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89747

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH (No.) 1910 Ellwood Place St., 8 Ward)
City of BALTIMORE:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Stein

(a) Residence No. 1910 Ellwood Place St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, or ~~Divorced.~~ (~~Write the word.~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Lillian Stein

6-DATE OF BIRTH (month, day and year) Sept. 12 1877

7-AGE. 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laber
(b) General nature of Industry, business, or establishment in which employed (or employer) 840
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Casper Stein

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Eva Sander

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14-(Informant) Mrs. Laura Elliott
(Address) 1910 Ellwood Place

AUG 26 1924

Aug 1924 Hall Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 23/924

17- I HEREBY CERTIFY, That I attended deceased from Aug 9 1924 to Aug 23 1924 that I last saw h[illegible] alive on Aug 23 1924 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Pfeiffer M. D.

8/23, 1924 (Address) 956 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug. 26, 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1735 Harford Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D-89748

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89748

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 W. Cross ST., 21 WARD)

2-FULL NAME Sarah Nelson

(a) RESIDENCE NO. 506 W. Cross ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Burris Nelson

6 DATE OF BIRTH (month, day, and year) —— 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northampton Co. Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Butler

(Address) 503 W. Cross St

Filed AUG 26 1924 H. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug- 23 1924

17 I HEREBY CERTIFY, That I attended deceased from July- 5, 1924, to Aug 23, 1924, that I last saw her alive on Aug - 23, 1924, and that death occurred, on the date stated above, at 2 — 30 p. m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis Chronic Nephritis - Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine Exam.

(Signed) Wm Francisco, M. D.

Aug 25, 1924 (Address) 1200 W Fay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 26 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and undertakers should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89749

D 89749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 China ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Coby

(a) RESIDENCE. No. 806 China ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizth Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mollie Smith
(Address) 806 China St

AUG 26 1924

[illegible]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1924

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to Aug. 23, 1924, that I last saw h alive on Aug. 22, 1924, and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage
a few hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Carcinoma
(duration) yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) John H. Toadvine M. D.

8/22/24 (Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 26 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89750

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 W. Hughes St. ST., 23 WARD)

2-FULL NAME Thelma M. Brooks. (C).

(a) RESIDENCE NO. 929 Plum Al. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) July 20, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Brooks. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Robinson. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mary Brooks. (C) (mother).
(Address) 929 Plum Al.

AUG 26 1924

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rickets.
Broncho-pneumonia.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Aug. 26, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn ct	Aug 26 1924
20 UNDERTAKER	ADDRESS
A. L. Brown & Son	1818 Mad Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89751

HEALTH DEPARTMENT—CITY OF BALTIMORE 89751

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 E. Clement ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Augustine Geiger

(a) RESIDENCE. No. 428 E. Clement ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Russell Geiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eva Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Russell Geiger

(Address) 428 E Clement St.

Filed AUG 25 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 23. 1924.

17 I HEREBY CERTIFY, That I attended deceased from 7. 1. 24. 19 .. to 8. 23. 1924

that I last saw him alive on 8. 23. 1924

and that death occurred, on the date stated above, at 10.09P m.

The CAUSE OF DEATH* was as follows:

Contentia acute Endocarditis

(duration) yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary) Cerebral Embolus 5 min.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical signs & symptoms

8/23. 1924 (Signed) J. Edwin Norris M. D.

(Address) 107 E West st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 26 1924
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Bright

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89752

1739 D 89752

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH John Hopkin Hospital

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kutnick

(a) RESIDENCE NO. 730 S. Bond St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb 4, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christian D. Kutnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mason B. Burnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) Records John Hopkin Hospital

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

Burial Permit Clerk

AUG 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1924, to August 25, 1924, that I last saw him alive on August 25, 1924, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Septicemia (Staphylococcus)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Gastro Intestinal Indigestion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bagg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL Aug 26 1924

20 UNDERTAKER M. F. Sadowski.

ADDRESS 905 S. Ann

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 911 Russell St., 21 Ward)

Registered No. 100

2-FULL NAME Eugene Weathers

(a) Residence No. 911 Russell St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) June 9 1923

7-AGE, 1 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town), (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Eugene Weathers

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Va

12-MAIDEN NAME OF MOTHER, Elsie Thomas

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Md

14- (Informant) Elsie Thomas

(Address) 911 Russell st

15- Robert F. Harrison,

Filed ....., 192.... Registrar.

Burial Permit Clerk.

AUG 26 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 25/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 m., 19 24, to Aug 25 m., 19 24

that I last saw him alive on Aug 24 m., 19 24,

and that death occurred, on the date stated above, at 1:42 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 24 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) James A. Cooke, M. D.

, 19 (Address) 655 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL, Aug 26, 19 24

20-UNDERTAKER. Geo A Boyle

ADDRESS 406 N Carey St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89754

161-001

D 89754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womans Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette + John ST., 17 WARD)

2-FULL NAME Baby Williams

(a) RESIDENCE No. 2722 Harford Rd. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or 42 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clinton Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md.

12 MAIDEN NAME OF MOTHER Mary Knarr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Clinton L. Williams

(Address) 2722 Harford Road

15 AUG 26 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26th 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 26th, 1924, to Aug. 26th, 1924, that I last saw him alive on Aug. 26th, 1924, and that death occurred, on the date stated above, at 8:40 A.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys exam

(Signed) Frederick A. Snyder, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 26 1924
20 UNDERTAKER Wm Cook	ADDRESS 202 E 10th

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89755

CERTIFICATE OF DEATH.

45 D 89755

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. 4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Strawbridge

(a) RESIDENCE NO. 1741 Montpelier St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 6

6 DATE OF BIRTH (month, day, and year) Dec 1872

7 AGE Years	Months	Days	If LESS than 1 day,.....hrs. or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Aug Mumner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Strawbridge

(Address) 1741 Montpelier St

15 Filed ....., 19.... Robert P. Harrison, Registrar

AUG 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-25 1924

17

I HEREBY CERTIFY, That I attended deceased from July-13, 1924, to Aug-25, 1924, that I last saw h er alive on Aug 25, 1924 and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Colloid Carcinoma of Rectum

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 17 24 & Aug 11 24

Was there an autopsy? Yes - Partial

What test confirmed diagnosis? autopsy

(Signed) Henry V. P. Wilson M. D., M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 27 1924
20 UNDERTAKER	**ADDRESS**
Hannah Cadwes	1034 Hanover

IN B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Ex[illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89756

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 330 N. Gilmor St., 19 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Jessie Bell

(a) Residence No.. 330 N. Gilmor St. St.,.....Ward.....

(Usual place of abode) 40

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr H Bell

6-DATE OF BIRTH (month, day and year) Feb 28, 864

7-AGE, 59 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Essex Co Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Nancy Johnson

13-BIRTHPLACE OF MOTHER (city or town)..... Va (State or Country),

14- (Informant) William H. Bell

(Address) 330 N. Gilmor St.

15- Filed AUG 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 25 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Aug 25, 1924, that I last saw h. alive on Aug 24, 1924, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Organic Disease Heart

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical Observation

(Signed) Jas L Hoopes, M. D.

Aug 25 1924 (Address) 3463 Dr St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn — DATE OF BURIAL, August 27 1924

20-UNDERTAKER, Leonard Whalen — ADDRESS 1332 Sarah St

WHITE PAPER, WITH ORANGE INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89757

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., Balto md. WARD).

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Skruch

(a) RESIDENCE NO. 516 S. Rose St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Stanislaw Skruch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: John J. Skruch

(Address): 1936 Eastern ave

AUG 26 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1924, to Aug 26, 1924, that I last saw him alive on Aug 25, 1924, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular disease

Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/15/24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) K. W. Sollers M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: aug. 28 1924

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89758

CERTIFICATE OF DEATH.

X 130 89758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 N. Calhoun ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Ball

(a) RESIDENCE NO. 1148 N. Calhoun ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none. (DD)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Arthur Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Blanche Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Emily Ball
(Address) 1148 N. Calhoun St.

15 Filed AUG 26 1924 Robert P. Harrison, Registrar
1719
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ... yrs. ... mos. 1 ds.

(Signed) J. J. T. Hennessy, (Coroner.) M. D.

Aug. 25, 1924 (Address) 202 Saint Paul Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 26 1924

20 UNDERTAKER

ADDRESS

Commissioner of Health.

DEPUTY

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUESTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89759
174880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89759

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Barker

(a) RESIDENCE NO. 1835 Jefferson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olivia W. Barker

6 DATE OF BIRTH (month, day, and year) Sept 14 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed OCT 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1924, to Aug 25, 1924, that I last saw him alive on Aug 25, 1924, and that death occurred, on the date stated above, at 5.36 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas causing obstruction of bile ducts

2

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of 8-22-24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	aug 27 1924

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North Ave

OG 26 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1078

MD 89760

HEALTH DEPARTMENT—CITY OF BALTIMORE

MD 89760

CERTIFICATE OF DEATH

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. 44

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver K. Wilds

(a) RESIDENCE NO. Vicksburg. Miss. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Wilds

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

166

9 BIRTHPLACE (city or town) (State or country) Natchez Miss

PARENTS

10 NAME OF FATHER Oliver Wilds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) " " (State or country)

14 Informant Records

(Address) Johns Hopkins Hospital

15 AUG 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1924, to Aug. 26, 1924, that I last saw him alive on Aug. 26, 1924, and that death occurred, on the date stated above, at 7 55 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Miss.

Did an operation precede death? Yes Date of Aug 21, 24

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Warfield M. Firor, M. D.

8/26 1924 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Natchez Miss — DATE OF BURIAL Aug 26 1924

UNDERTAKER John C Mitchell — ADDRESS 1201 W Fayette

AUG 26 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89761

CERTIFICATE OF DEATH.

90 D 89761

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Pennsylvania ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson Winfield Pearce

(a) RESIDENCE NO. 1408 Pennsylvania ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 87 Emma V. Pearce

6 DATE OF BIRTH (month, day, and year) June 5, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) 053

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER David Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eleanor Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Emma V. Pearce
(Address) 1408 Penna Ave

15 Filed Robert F. Harrison, Registrar

2 6 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1924

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Aug 24, 1924, that I last saw h.. alive on Aug 24, 1924, and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Hammond, M. D.

, 19 (Address) 1929 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: My Lady's Manor Balto. Co. — DATE OF BURIAL: Aug 27 1924

20 UNDERTAKER: Harry Hewitzke — ADDRESS: 153 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Gilmor ST.; 19 WARD) REGISTERED No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard White

(a) RESIDENCE. No. 415 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Francis White.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Mrs Francis White.
(Address) 415 N. Gilmor St.

15 Filed AUG 26 1924 19 Robert P. Harrison, Registrar

Burial Permit Given #

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1924

17 I HEREBY CERTIFY, That I attended deceased from 7/31 —, 1924, to 8/23, 1924, that I last saw him alive on 8/23, 1924, and that death occurred, on the date stated above, at 5— P m.

The CAUSE OF DEATH* was as follows: —

Arterio sclerosis Cerebral apoplexy and paralysis since 7/31 —
since 8/21-24

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Burkhart M. D.

8/25. 1924 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 27 1924

20 UNDERTAKER Mrs Jas. H. Dennis

ADDRESS 1303 Pressman St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Alta ave. & Mapleave 77 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M Loskarn

(a) Residence No. Alta ave & Mapleave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, Widow or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Loskarn

6-DATE OF BIRTH (month, day and year) February 26. 1851.

7-AGE. 73 yrs. mos. ds.

If LESS than 1 day. hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Wife

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Preller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna M. Herbst

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Anna M. Cranston

(Address) Alta & Mapleave

15- AUG 27 1924 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 24 1924

17- I HEREBY CERTIFY, That I attended deceased from August 15 1924 to August 24 1924

that I last saw her alive on August 24 1924

and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Collentine M. D.

Aug. 26. 1924 (Address) 1810 E Baltimore St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer — DATE OF BURIAL: Aug. 27. 1924

20-UNDERTAKER: Wendell Rippelton — ADDRESS: 37 Hundt

N. B.—WRITE PLAINLY, WITH UNFADING INK—TYPEWRITING PREFERRED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 Grindall ST.: 24th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Lambert Miller.

(a) RESIDENCE. No. 237 Grindall ST., 24th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John C. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Edna V. Lampert

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant (mother.) Mrs. Edna Lambert Miller
(Address) 237 Grindall St

15 [illegible]

AUG 27 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1924

17

I HEREBY CERTIFY, That I attended deceased from August 7, 1924, to August 26, 1924, that I last saw him alive on August 25, 1924, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) 0 yrs. 5 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	8-27 1924
20 UNDERTAKER Earl B Harle 1165	ADDRESS West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39765

CERTIFICATE OF DEATH.

1820

1-PLACE OF DEATH Blue Pond,

CITY OF BALTIMORE: (No. Cherry Hill. Westport. ST., 24 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Huber.

(a) RESIDENCE No. 1236 Wall Street. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) October 2, 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Press feeder.

(b) General nature of industry, business, or establishment in which employed (or employer): Parker Metal

(c) Name of employer: Decorating Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Huber.

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Jersey.

12 MAIDEN NAME OF MOTHER: Sophie K. Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Henry Huber. (father).

(Address): 1236 Wall Street.

15 AUG 27 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
While in bathing.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Aug. 26, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co	8-28 1924
20 UNDERTAKER	ADDRESS
Ehrlich Harle	115 E West St

NOTE—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 89766

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S. Bond ST., 3 WARD)

2-FULL NAME Walter von Krauze

(a) RESIDENCE NO 616 S. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Krauze

6 DATE OF BIRTH (month, day, and year) May 16 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Luminely 029

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Walter Krauze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14
Informant Eva Krauze
(Address) 616 S. Bond St

15
Filed AUG 27 1924 192 GD Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Faulkner, M. D. (Coroner.)

Aug 26, 1924 (Address) 702 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Aug 27 1924.
20 UNDERTAKER	ADDRESS
Jacob Dialkowski	426 S. Bond St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89767 43 D 89767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1242 W Pratt ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond A. Hahn

(a) RESIDENCE. NO. 1243 W Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis Hahn

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mr Hahn

(Address) 1308 W Lombard St

15 Filed ..... 19 ..... Registrar

AUG 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from April, 1924, to Aug 26, 1924, that I last saw him alive on Aug 23, 1924, and that death occurred, on the date stated above, at 8:30A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

about (duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) W. W. Dupuy, M. D.

, 19 (Address) 1324 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western.	Aug 28 19
20 UNDERTAKER John Fields	ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89768

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Robinson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Kraus.

(a) RESIDENCE NO. 615 N Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Female	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Joseph Kraus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Maryland

12 MAIDEN NAME OF MOTHER Johannah Janda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fairbery Illinois

14 Informant Joseph Kraus (Address) 608 Robinson St.

15 Filed AUG 27 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-1924

17

I HEREBY CERTIFY, That I attended deceased from 8-19 ....., 19 24 ....., to 8-26 ....., 19 24

that I last saw h.. alive on 8-25 ....., 19 24

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1924 (Address) 1500 N Mott Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph Cemetery Baltimore County	Aug 29 24
20 UNDERTAKER	ADDRESS
Wm E Miller	2334 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89769 D 89769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 129

1-PLACE OF DEATH 609 N. Central Ave. Registered No.....

City of BALTIMORE: (No..... St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Chambers

(a) Residence No. 609 N. Central St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced Husband of (or) Wife of Annie Chambers

6-DATE OF BIRTH (month, day and year) Dec. 1. 1870.

7-AGE 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Oliver Chambers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Annie Chambers

(Address) 609 N. Central

Filed AUG 27 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-23-24

17- I HEREBY CERTIFY, That I attended deceased from August 8th 1924 to August 23. 1924

that I last saw him alive on 8-23 1924

and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease & Complications (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. W. Kennard M. D

, 19 (Address) 708 Ensor St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville cemetery DATE OF BURIAL. Aug 27 1924

20-UNDERTAKER. Miller & Davis ADDRESS 515 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89770

D 89770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 430 East ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Abercrombie Brooks

(a) RESIDENCE. NO. 430 East St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Samuel D. Brooks

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Toronto (State or country) Canada.

PARENTS

10 NAME OF FATHER James Wm. Abercrombie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada.

12 MAIDEN NAME OF MOTHER Marian Benedict

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York State.

14 Informant Chas. M. Moore

(Address) 429 East St

AUG 27 1924

....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from March. 1924, to Aug. 26, 1924, that I last saw her alive on Aug. 25, 1924, and that death occurred, on the date stated above, at 9.55 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwee, M. D.

, 19 (Address) 31 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 29 1924
20 UNDERTAKER Geo M. Frick & Son	ADDRESS 811 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89771 HEALTH DEPARTMENT—CITY OF BALTIMORE 179 D 89771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 Orchard ST.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Browne

(a) RESIDENCE. No. 546 Orchard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Browne

6 DATE OF BIRTH (month, day, and year) Aug-10-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Viola Bryant

(Address) 546 Orchard St

15 Filed AUG 27 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/24

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to Aug. 24, 1924, that I last saw h alive on Aug 23, 1924, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Humphries M. D.

8/27/24 (Address) 1019 Dimt Hill Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem DATE OF BURIAL Aug 27 24

20 UNDERTAKER Edward F Mealey ADDRESS 1019 Dimt Hill Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Pleasant ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Fulda

(a) RESIDENCE NO. 126 N Pleasant ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29—

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) Richmond
(State or country) Va

PARENTS

10 NAME OF FATHER Joseph L Fulds

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Martha Veney

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Maggie Conway

(Address) 823 Bruckline St

15 Filed AUG 27 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17

I HEREBY CERTIFY, That I attended deceased from June 30th, 1924, to Aug 25th, 1924.

that I last saw h[illegible] alive on Aug 25th, 1924.

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Acute Pythius

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 607 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Richmond Va

DATE OF BURIAL Aug 28 1924

UNDERTAKER Samuel Wheeley

ADDRESS Saddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89773

CERTIFICATE OF DEATH.

24-001 D 89773

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Pierce st ST., 18 WARD)

2-FULL NAME Edward Johnson

(a) RESIDENCE No 906 Pierce st ST., WARD

(Usual place of abode)

length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER L

13 BIRTHPLACE OF MOTHER (city or town) L
(State or country)

14 Informant E. Johnson
(Address) 906 Pierce st

15 Filed AUG 27 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) H H Kemp, M. D.
(Coroner.)

8-27, 1924 (Address) 117 N. Paca st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Auburn Cem	8/27/24
20 UNDERTAKER	ADDRESS
Dennis Corbett	Penn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89774

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 N Stockton St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Custis

(a) Residence No. 1121 N Stockton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Chas Custis

(Address) 1121 Stockton St

15- Filed ..... 192.. ..... Registrar.

AUG 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/24/24

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to Aug 24, 1924, that I last saw h.. alive on Aug 24, 1924 and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Heart Disease

(Duration) yrs. 3 mos. 16 ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W H McCurdy M. D.

, 19 (Address) 1230 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL 8/27/24

20-UNDERTAKER, David Easton — ADDRESS 916 E Pratt

IMPORTANT—NURSES AND PHYSICIANS REPORTING DEATHS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 89775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94 D 89775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5005 Hamilton ave ST., Howard Park 28 WARD)

2-FULL NAME Pauline F. H. Price

(a) RESIDENCE No. 5005 Hamilton ave ST., Howard Park WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence W. Price

6 DATE OF BIRTH (month, day, and year) May 2 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Duluth (State or country) Minnesota

PARENTS

10 NAME OF FATHER William W. Hemsley

11 BIRTHPLACE OF FATHER (city or town) Queenstown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret N. Bowie

13 BIRTHPLACE OF MOTHER (city or town) Prince Georges Co (State or country) Maryland

14 Informant Mrs. James Barnett

(Address) 500 Kensington Ave - Balto

15 Filed AUG 27 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Aug 26, 1924, that I last saw h[illegible] alive on Aug 26, 1924, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Arthritis (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) [illegible] ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) W. Bagnall M. D.

19 (Address) 2429 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 28 1924
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Carlton St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 39776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39776

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 783 Gwyn St. 17 Ward)

2-FULL NAME John T. Bowie

(a) RESIDENCE. No. 783 Gwynn St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Bowie

6 DATE OF BIRTH (month, day, and year) [illegible] 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER John T. Bowie Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. T. Bowie

(Address) 783 Gwynn St.

15 [illegible] Robert P. Harrison, Registrar

Burial Permit Clerk.

AUG 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26/1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1924, to Aug. 26, 1924

that I last saw h in live on Aug 26, 1924

and that death occurred, on the date stated above, at 6:45 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Humphries M. D.

(Address) 1014 W Lind Ave City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spnce.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 29 1924
20 UNDERTAKER Mrs Ida Snowden	ADDRESS 1745 Ashland Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 39777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39777

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Sheridan

(a) RESIDENCE No. 1623 N. Port St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bakery Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 666

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Asbury Sheridan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Sarah E. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Sarah E. Sheridan

(Address) 1623 N Port St

15 AUG 27 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1924, to Aug 26, 1924, that I last saw him alive on Aug 25, 1924 and that death occurred, on the date stated above, at 12 20 p m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Primary)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Suppression of urine & Paralytic Ileus (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug 18, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. Sheridan, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL AUG 28 1924, 19

20 UNDERTAKER Geo W Little

ADDRESS EDMONDSON AVE.

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 Potomac Ave St., Ward) 25 160

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland G. Burchett.

(a) Residence No. 100 Potomac Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 21 1924

7-AGE. yrs. mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Brooklyn Md

PARENTS

10-NAME OF FATHER Major C Burchett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Anna G. Houghtling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Mrs Major C Burchett

(Address) 100 Potomac Ave

15- Filed AUG 27 1924 192 Robert F. Duncan, Md Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1924 to Aug 26 1924

that I last saw h— alive on Aug 26 1924

and that death occurred, on the date stated above, at 7.15 p m.

The CAUSE OF DEATH* was as follows: Icterus-Neonatorum

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) X

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis? Clinical

(Signed) S. Paul Straus M. D.

, 19 (Address) 1340 E Chase

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 27 1924

20-UNDERTAKER John F Denny ADDRESS 715 Light St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 89779 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 Battery Ave St., 24 Ward)

Registered No. 129

2-FULL NAME John T Eaton

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1115 Battery Ave St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E Eaton

6-DATE OF BIRTH (month, day and year) Oct 5 1835

7-AGE. 88 yrs. 10 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Boiler Maker

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER. John T Eaton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Ann Topline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14- (Informant) Mrs Margaret E Eaton

(Address) 1115 Battery Ave

15- Filed Robert P. Harrison, Registrar.

AUG 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26 1924

17- I HEREBY CERTIFY, That I attended deceased from March 18 1918 to Aug 26th 1924

that I last saw him alive on Aug 25 1924

and that death occurred, on the date stated above, at 1255 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) several yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C. B. Buxton M. D.

8/26/24 19 (Address) 301 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill

DATE OF BURIAL. Aug 27 1924

20-UNDERTAKER. John F Denny

ADDRESS 715 Leg St Ed

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89780

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Arnold

(a) Residence No. 14 Spring St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Milton Arnold

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15- AUG 27 1924 Robert P. Harrison, Registrar.

Burial Permit, Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-23-24

17- I HEREBY CERTIFY, That I attended deceased from 8-21, 1924 to 8-23, 1924

that I last saw h— alive on 8-23, 1924

and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis; Auricular Fibrillation; Myocardial degeneration (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext.

(Signed) Claude S. Drake, M. D.

8-23, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ... 19..

20-UNDERTAKER. ADDRESS

Commissioner Health. AUG 27 1924

Bur. Wm. H. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D 89781

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Robert Braswell

(a) RESIDENCE NO. Greensboro Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Delaware
(State or country)

PARENTS

10 NAME OF FATHER Thomas Braswell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Caroline Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delaware

14 Informant Dr. Carroll Univ. Hosp
(Address) Green & Lombard

15 [illegible] 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1924, to Aug 27, 1924, that I last saw him alive on Aug 27, 1924 and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Inoperable Abdominal Tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Aug 25

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Marsh, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro Md DATE OF BURIAL Aug 27 1924

UNDERTAKER John O. Mulcuee ADDRESS 21 W Fayette

AUG 27 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89782 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89782

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Carter

(a) Residence No. Boston St. (Houseboat) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Carter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Morris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Municipal Hospital Records

(Address)

15- Filed AUG 27 1924 192 H. Lam Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-24-24

17- I HEREBY CERTIFY, That I attended deceased from 7-31, 1924, to 8-24, 1924, that I last saw him alive on 8-24, 1924, and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Senile Detenoration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude G. Drace, M. D.

8-24, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lacelle Park — DATE OF BURIAL, 8/28, 1924

20-UNDERTAKER, J. J. Gahagan — ADDRESS 131 S. Eight St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89783

D 89783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

447

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 20 WARD)

2-FULL NAME William Pellissier

(a) RESIDENCE No. 2110 Ashton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed AUG 27 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 4-22, 1924, to 8-22, 1924, that I last saw him alive on 8-22, 1924, and that death occurred, on the date stated above, at 5 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude T Bruce, M. D.

8-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 8/28 1924

20 UNDERTAKER J. J. Fahey Sons

ADDRESS 131 E Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 89784

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 N. Bruce St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Baynor

(a) Residence No. 616 N. Bruce St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Febry 28/24

7-AGE. — yrs. 5 mos. 29 ds. If LESS than 1 day, ... hrs. or ✓ min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph Baynor

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Lillie Colvin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Geo. C. Shannon

(Address) 700 Fulton ave

15- Robert P. Harrison, 1924 Registrar.

AUG 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 27-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 19 24 to Aug 27 19 24

that I last saw h. alive on Aug 26. 19 24

and that death occurred, on the date stated above, at 1.40a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Dentition

(Duration) ✓ yrs. ✓ mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) George C. Shannon M. D

8/27, 1924 (Address) 700 Fulton ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Fairview DATE OF BURIAL. Aug 28, 1924

20-UNDERTAKER Geo. W. Fraser & Co ADDRESS 1465 Druid

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89785

CERTIFICATE OF DEATH.

+ 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Moore

(a) RESIDENCE No. 103 York Rd., Towson, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apr. 17, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Towson, Md.
(State or country)

PARENTS

10 NAME OF FATHER James H. Moore

11 BIRTHPLACE OF FATHER (city or town) Towson, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marie E. Bolger

13 BIRTHPLACE OF MOTHER (city or town) Phila, Pa
(State or country)

14 Informant Mother Address 103 York Rd Towson

15 Filed AUG 27 1924, 19 Robert [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1924, to Aug. 26, 1924, that I last saw her alive on Aug. 26, 1924, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Toxic diarrhea

Exhaustion

2 wks. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Donaldson M.D.

, 19 (Address) 101 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Marie Towson — DATE OF BURIAL Aug 28 1924

20 UNDERTAKER William Cook — ADDRESS 502 E Mt

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89786 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89786

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No.....ST., 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kolbe

(a) RESIDENCE No. Eastern Avenue Road Balto. Co. Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anna Kolbe

6 DATE OF BIRTH (month, day, and year) Dec - 22 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/b

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Union Hill N.J.

PARENTS

10 NAME OF FATHER Antone Kolbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Thomas ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Kolbe (Address) 411 - E Lafayette

15 AUG 27 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1924, to Aug 27th, 1924, that I last saw him alive on Aug 27th, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Uraemic convulsions followed by coma.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bright disease kidneys unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam & Lab

(Signed) H. B Sylvest M. D.

, 19 (Address) St Jos. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 ~~PLACE OF BURIAL, CREMATION~~ OR REMOVAL	DATE OF BURIAL
New York City	Aug 27 1924
20 UNDERTAKER	ADDRESS
William Cook	502 E Monument

MARRIAGE REGISTRATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89787

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 V

D 89787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., No. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Gilbrock (Gilbuch)

(a) Residence No. Bay View Asylum St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ned Brown

6-DATE OF BIRTH (month, day and year) 1835

7-AGE. 89 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- AUG 28 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-26-24

17- I HEREBY CERTIFY, That I attended deceased from 8-23, 1924 to 8-26, 1924 that I last saw h[illegible] alive on 8-26, 1924 and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude D Drane M. D.

8-27, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	Aug 29, 1924
20-UNDERTAKER.	ADDRESS
Frank Enoch & Son	1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89788 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89788

CERTIFICATE OF DEATH.

100-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note carefully that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 N. Spring ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Boston.

(a) RESIDENCE No. 1213 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	Colored.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/12/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. L. Boston. (Address) 1213 N. Spring St.

15 AUG 28 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 1924, to Aug 24, 1924, that I last saw h[illegible] alive on Aug 24, 1924 and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac degeneration
(Myocarditis)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hamilton M. D.

8/27. 1924 (Address) 733 Arsenal St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery. DATE OF BURIAL Aug. 28 1924

20 UNDERTAKER George J. Ruth. ADDRESS 1735 Harford Ave.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39789

CERTIFICATE OF DEATH.

D 39789

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2040 Ashland ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina A. Wirth

(a) Residence No. 2040 Ashland ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Julius R. Wirth

6-DATE OF BIRTH (month, day and year) Jan 9, 1867

7-AGE, 57 yrs. 7 mos. 18 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-Informant Julius R. Wirth

(Address) 2040 Ashland

15-Filed AUG 28 1924 192... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 27, 1924

17-I HEREBY CERTIFY, That I attended deceased from May 1 24 to Aug 27 24

that I last saw h. alive on Aug 27 24

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(Duration) yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

Aug 28 1924 (Address) 841 N Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL, Aug. 30, 1924

20-UNDERTAKER, Sorkler & Kirkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Norman a Walker) ✓

D 89790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89790

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Addison Walker.

(a) RESIDENCE NO. 1312 N. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	0	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Norman Addison Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER June Gloss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14

Informant Mrs Norman Walker

(Address) 1312 N Franklin

AUG 28 1924

Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 19 24

17

I HEREBY CERTIFY, That I attended deceased from August 19, 19 24, to August 26, 19 24,

that I last saw him alive on August 26, 19 24

and that death occurred, on the date stated above, at 11.00 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis.

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald C Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Aug 27 19 24

20 UNDERTAKER H M Routson

ADDRESS 2238 W

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89791

11-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Aulander Ave ST., 7 WARD)

2-FULL NAME William Hughes

(a) RESIDENCE NO. 911 Aulander ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colord

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): cambridge md

PARENTS

10 NAME OF FATHER: elzender hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): cambridge md

12 MAIDEN NAME OF MOTHER: sarah jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: laura hughes
(Address): 911 aulander ave

AUG 28 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Aug 25, 1924, that I last saw him alive on Aug 24, 1924, and that death occurred, on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Contributory with Acute Bronchitis.

(duration) ... yrs. ... mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Clemson M. D.

19 24 (Address) 203 E McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
auburn cemetery	aug 28 1924
20 UNDERTAKER	ADDRESS 1631 orleans st
Edward Bryan	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39792

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Flagg

(a) Residence No. 1242 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1877

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), S. Carolina

PARENTS:

10-NAME OF FATHER, Huron Flagg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), S. Carolina

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), S. Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- AUG 28 1924 192 JG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-27-24

17- I HEREBY CERTIFY, That I attended deceased from 7-21, 1924 to 8-27, 1924

that I last saw him alive on 8-26, 1924

and that death occurred, on the date stated above, at 1:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

and Aortitis, probably syphilitic.

Myocardial degeneration

(Duration) yrs. 8 mos. (estimated)

CONTRIBUTORY (Secondary) Myocardial failure

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude G. Rood, M. D.

8-27-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodberry cemetery

DATE OF BURIAL. 8-31 1924

20-UNDERTAKER. Edward Bryson

ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89793 HEALTH DEPARTMENT—CITY OF BALTIMORE 89793

CERTIFICATE OF DEATH.

1-PLACE OF DEATH So. Balto. Gen'l. Hosp. 25 X 100-001

CITY OF BALTIMORE: (No. 1213 Light St ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Dalziel

(a) RESIDENCE No. 628 1st St. West Port WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	1	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work INFANT

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Toranto Canada.

PARENTS

10 NAME OF FATHER James Dalziel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margie Nesbit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Toranto Canada

14 Informant James Dalziel

(Address) 628 First St Westport

Filed AUG 28 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1924, to Aug 26, 1924, that I last saw her alive on Aug 26, 1924 and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

DIFFUSE BRONCHO PNEUMONIA.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) PULMONARY EDEMA

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 628 1st St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 29 1924
20 UNDERTAKER	ADDRESS
Nelson E. Stiles	320 Md. Ave Westport

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89794 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89794

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1307 Eastern Ave St., 2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Goetze.

(a) Residence No. 1307 Eastern Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 7, 1844

7-AGE. 80 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 66

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Carson Goetze

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Clark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Chestertown Md.

14-

(Informant)

(Address)

AUG 28 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 28, 1924 to Aug 26, 1924

that I last saw him alive on Aug 26, 1924

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) nephritis, arterio-sclerosis, hypertension

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Dobihal M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Aug 29, 1924

20-UNDERTAKER, H. Sander & Sons

ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89795

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. Orlando Ave Hamilton 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth Fornoff

(a) Residence No. Orlando Ave Hamilton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Fornoff

6-DATE OF BIRTH (month, day and year): Feb. 18. 1856

7-AGE: 68 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS:

10-NAME OF FATHER, Sebastian Vogel

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Riedel

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant) Philip Fornoff

(Address) Orlando Ave Hamilton

15-

Filed AUG 28 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1922 to August 27 1924

that I last saw her alive on August 27 1924

and that death occurred, on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH* was as follows: (1st in April 1924 2nd attack) Jan 17-24.

Cerebral Apoplexy (2nd attack)

arterial Hypertension

auricular fibrillation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Louis H. Hammen M. D.

, 19 (Address) 722 N. Haywood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cemetery	Aug. 31., 1924
20-UNDERTAKER.	ADDRESS
H. Gander & Sons	710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89796

HEALTH DEPARTMENT—CITY OF BALTIMORE

Todd
D 89796

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 3302 West North ST., 15 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fillie May Hoffman

(a) RESIDENCE No. 3302 West North ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry P. Hoffman

6 DATE OF BIRTH (month, day, and year) March 11-1865

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER James Crew
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Hannah J Talbot
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry P. Hoffman
(Address) 3302 W. North Ave

Filed AUG 29 1924, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1923, to Aug 27, 1924, that I last saw her alive on Aug 27, 1924 and that death occurred, on the date stated above, at 9 H m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes. Date of Oct-1923
Was there an autopsy? No.
What test confirmed diagnosis? Path.

(Signed) Henry C. Todd, M. D.
8/27 1924 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery
DATE OF BURIAL Aug 29 1924

20 UNDERTAKER W. Cook
ADDRESS 502 E Nor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sr. Libuba 2347 Eutaw Place

D 89797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89797

159-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1512 N. Pine ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Brandt

(a) RESIDENCE No. 1512 N. Pine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Louis Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E McGreary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs John Brandt (Address) 1512 N. Pine St.

AUG 28 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24 1923 to Aug. 26th 1924, that I last saw h[illegible] alive on Aug. 26th 1924 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart
Atresia of [illegible] trunc

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Secondary Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lucille Liberles, M. D.

8/27, 1924 (Address) 2347 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Moby Rudemer Aug 29 1924

20 UNDERTAKER — ADDRESS

H. Lee Cook 502 E. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89798 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89798

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 East Read St. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hillyard Cameron Lee

(a) RESIDENCE NO. 9 East Read ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Stokes Lee

11 BIRTHPLACE OF FATHER (city or town) Charleston (State or country) County Carolina

12 MAIDEN NAME OF MOTHER Sarah Mallett

13 BIRTHPLACE OF MOTHER (city or town) / (State or country)

14 Informant Mrs H. C Lee (Address) 9 E. Read St

AUG 28 1924 H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ July 27, 1924, ~~to~~ ~~19~~, that I last saw h~~im~~ alive on July 27 1924, ~~19~~, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

~~Reveal~~ (duration) yrs ~~mos~~ ~~ds~~

CONTRIBUTORY (Secondary) 0

0 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Carpal examination by pathologist

(Signed) Hugh H. Young, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Aug 28 1924

20 UNDERTAKER Henry W. Jenkins Sons — ADDRESS McCulloh & Orchard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39799 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39799

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Haltzman

(a) RESIDENCE No. 1108 N. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Haltzman

6 DATE OF BIRTH (month, day, and year) June 23 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work (Refrigerator Engineer)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. City.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. R. Haltzman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura A. Foss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary F. Haltzman
(Address) 1108 N. Eutaw St.

Filed AUG 28 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in Head. (suicide).

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Aug. 28, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Aug 29 1924
20 UNDERTAKER Eckhardt & Co	ADDRESS 1723 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 39800

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 118 D 39800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Carl Wagner

(a) RESIDENCE NO. 511 "C" st, Sparrows Point ST., WARD Sparrows Point Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel-worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, Mass.

PARENTS

10 NAME OF FATHER Mr. John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Fridler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant (Address) Miss Mary Wagner (sister) Nr 2nd st. Stapleton, Staten Isl.

15 Filed ....., 19.... Robert P. Harrison, Registrar

AUG 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1924, to Aug 27, 1924, that I last saw him alive on Aug 27, 1924 and that death occurred, on the date stated above, at 1:47 a m.

The CAUSE OF DEATH* was as follows:

Strangulated Indirect Inguinal Hernia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 20 1924

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Henry L.P. Wilson Jr M.D. M. D.

8/27, 1924 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington Mass.	8/28 1924

20 UNDERTAKER E. G. Kyhl ADDRESS 1st N. Broadway

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 89801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for the Aged of M.E. Church

City of BALTIMORE: (No. 400 N. Fulton Ave St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Burns,

(a) Residence No. Home for the Aged of the M.E. Church St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 9 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 13, 1835

7-AGE. 88 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS

10-NAME OF FATHER, Philip Eisle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Mary E. Kline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Helen E. Bennett

(Address) 400 N. Fulton Ave.

15-Filed 1924 Robert P. Harrison, Registrar.

AUG 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 27/24

17- I HEREBY CERTIFY, That I attended deceased from August 17 1924 to Aug 27 1924

that I last saw h[illegible] alive on Aug 26 1924

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 4 yrs. ✓ mos. ✓ ds

CONTRIBUTORY (Secondary) Senility

(Duration) ? yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) George C. Shannon M. D

8/27 1924 (Address) 700 Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug 29 1924
20-UNDERTAKER. George J. Smith	ADDRESS. 582 Hollins ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89802

CERTIFICATE OF DEATH.

129 D 89802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 n Bruce ST., 16 WARD)

2-FULL NAME Lucinda Green

(a) RESIDENCE No. 702 N Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Green

6 DATE OF BIRTH (month, day, and year) Nov 30 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co. (State or country) Va

PARENTS

10 NAME OF FATHER Henry Tunstall.

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Georgianna Bellfield

(Address) 707 Jones St

15 Filed AUG 28 1924, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Aug 25, 1924, that I last saw her alive on Aug 25 1924, and that death occurred, on the date stated above, at 8½ P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema and Cardiac stenosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Syphilis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

8/28, 1924 (Signed) Bernard S. French, M. D.

(Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn — DATE OF BURIAL Aug 30, 24

20 UNDERTAKER Sam'l N. Chase & Son — ADDRESS 1400 Madison

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89803 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1431 Mt Royal Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bushrod Marion Watts

(a) Residence No. 1431 Mt Royal Ave St., 11 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 19 ds How long in U. S., if of foreign birth? 63 yrs. 6 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine M. Watts

6-DATE OF BIRTH (month, day and year) Feb.-7-1861

7-AGE, 63 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Coal-

(b) General nature of industry, business, or establishment in which employed (or employer). Business

(c) Name of employer..... E.A.& B.M.Watts

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, J.Marion Watts

11-BIRTHPLACE OF FATHER (city or town)..Baltimore
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Harriett.V.Perry
Charlestown W.Va.

13-BIRTHPLACE OF MOTHER (city or town)..~~Baltimore~~
(State or Country), ~~Md.~~

14-

(Informant) Mr.B.R.Watts(Son)

(Address)..... 1431 Mt. Royal Ave

15-

Filed..... 19.. Robert P. Harrison Registrar.

AUG 28 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1. 24 to Aug. 26. 24

that I last saw him alive on Aug. 26 24

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, Aug. ....., 19 24

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. MONUMENT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 16 129

City of BALTIMORE: (No. 3305 Toone St., 16 Ward)

2-FULL NAME Charles W. Eberhart

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3305 Toone St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Eberhart

6-DATE OF BIRTH (month, day and year) Feb. 17-1840

7-AGE: 84 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired 30

(b) General nature of industry, business, or establishment in which employed (or employer): Steam but Eng

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City X

PARENTS.

10-NAME OF FATHER: Conrad Eberhart

11-BIRTHPLACE OF FATHER (city or town) (State or Country): City

12-MAIDEN NAME OF MOTHER: Mary A Imshy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14-

(Informant): Mrs Emma Deeb X

(Address): 3305 Toone St X

AUG 28 1924

Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): aug. 26-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 19 24 to Aug. 26 19 24

that I last saw him alive on Aug 25 19 24

and that death occurred, on the date stated above, at 6.30 PM

The CAUSE OF DEATH* was as follows:

Heart exhaustion

uraemia

(Duration) X yrs. X mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Bright's

disease (Duration) X yrs. 6 mos. X ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jas. L. Truax M.D.

Aug 26, 19 24 (Address) 2450 3d St E.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Ger Cathedral Cem	Aug 29. 19. 24
20-UNDERTAKER. J. J. Moran	ADDRESS 3006 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

174332

D 39805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D 39805

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Everett Cross

(a) RESIDENCE NO. Harford Conn ST., WARD Harford Conn.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Conn.
(State or country)

PARENTS

10 NAME OF FATHER Everett Cross

11 BIRTHPLACE OF FATHER (city or town) Conn.
(State or country)

12 MAIDEN NAME OF MOTHER Esther Tilly

13 BIRTHPLACE OF MOTHER (city or town) Mass.
(State or country)

14 Informant Parent
(Address) Same

15 Filed , 19 Robert P. Harrison, Registrar

AUG 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1924, to Aug 27, 1924, that I last saw him alive on Aug 27, 1924, and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (glioma)
(Malignant)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Conn

Did an operation precede death? Yes Date of Aug. 27-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological exa

(Signed) Warfield M Johnson M. D.

8/28. 1924 (Address) 9 W 4

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harford Conn	Aug 28 1924
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39806

CERTIFICATE OF DEATH.

11 D 39806

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie A. Snyder

(a) RESIDENCE No. 2416 Linden Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Snyder.

6 DATE OF BIRTH (month, day, and year) Feb 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER John A. Burns

11 BIRTHPLACE OF FATHER (city or town) Balt. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary C. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs. Carrie A. Snyder (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

AUG 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 , 1924 , to Aug. 27 , 1924 , that I last saw her alive on Aug. 27 , 1924 , and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Apperdix } 7 days
General Peritonitis }
Chronic Myocarditis — 6 years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus, Acute Cardiac Dilitation (duration) 48 hours yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 8/20/24

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) Jno A Youngblood, M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 29 1924
UNDERTAKER	ADDRESS
M. Tucker & Sons	North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 89807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52 D 89807

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will be held strictly responsible that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Penna. Ave. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Gunning

(a) RESIDENCE NO. 2322 Penna Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Bernard Mc Magarity

(Address) Woodburnie Ave, Govans

15 Filed AUG 28 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to Aug 26, 1924, that I last saw her alive on Aug 26, 1924, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans 5 yr.

Arteriosclerosis 5 yr.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw V Coolahan M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Aug 29th 1924

20 UNDERTAKER Henry C Brannigan

ADDRESS 517 N. Edwards St

Spec.—1-1021—M&T—1500 Bks.

1740 23 89808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 89808

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 1D ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McIntyre

(a) RESIDENCE NO. 129 St. Clement ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8th 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Peter McIntyre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Arietta Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant RECORD (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

AUG 28 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1924, to Aug. 27, 1924

that I last saw h alive on Aug 27, 1924,

and that death occurred, on the date stated above, at 3.15 p.m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. R. Bunn M. D.

..... 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem. DATE OF BURIAL Aug 29th 1924

20 UNDERTAKER E. Schlosman & Son ADDRESS 1039 Eastern Av

MARGIN RESERVED FOR OFFICIAL RECORD

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 Poplar Grove St., 16 Ward) 90

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Limerick

(a) Residence No. 1021 Poplar Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wilford Limerick

6-DATE OF BIRTH (month, day and year) Sept 7th 1848

7-AGE. 75 yrs. 11 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS:

10-NAME OF FATHER, James Blinco

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Dillo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

11- (Informant) Goldie M. Shilton

(Address) 1021 Poplar Grove st

15- Filed AUG 28 1924 Robert P. Harrison, 192 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 27/24

17- I HEREBY CERTIFY, That I attended deceased from July 10 19 24 to Aug 27 19 24

that I last saw her alive on Aug 26 19 24

and that death occurred, on the date stated above, at 3.25 p.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart—

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart—

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) Jno Zeiler M. D

19 (Address) 1122 Poplar Grove.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 29th 19 24
20-UNDERTAKER,	ADDRESS 1034
B. Schlosman & Son	Lanvale st

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 39810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39810

CERTIFICATE OF DEATH. X 16-00

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 N Calvert ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Jane Webster.

(a) RESIDENCE No. 4802 Washington Blvd ST., St. Louis Mo. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 4 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19-1918

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
5	11	28	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Duluth, Minn.

PARENTS

10 NAME OF FATHER Fletcher J. Webster

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Gladys M. Hogan

13 BIRTHPLACE OF MOTHER (city or town) Terrace

(State or country) Utah.

14 Informant Mr F Fletcher J Webster

(Address) St Louis Mo

15 Filed ..... 19.... Robert P. Harrison Registrar

Burial Permit Clerk

AUG 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25th 1924 to Aug 27th 1924.

that I last saw her alive on Aug 27th 1924.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Blue Ridge Summit

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam and

(Signed) Conting Rolen M. D.

1924 (Address) 1011 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	August 30 1924

20 UNDERTAKER Henry H Jenkins & Son Co ADDRESS Orchard & Mt Holladay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1 N. High St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa J. Roberts

(a) Residence No. Seven North High St., 99 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Chas Roberts

6-DATE OF BIRTH (month, day and year): March 17 1855

7-AGE: 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Mathews Gorske

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Anna Slyzanski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Mrs Bertha Ott

(Address): 7 N. High St

15-

Filed Aug 28 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 19 nt to Aug 28 19 nt

that I last saw h[illegible] alive on Aug 28 19 nt

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cachexia - Exhaustion

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Moses Paulson M. D.

19 (Address) 65 Exeter St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 29 1924

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1211 W. Fayette

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 28 1924

Spec.—1-10-21—M&T—1500 Blks.

D 89812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89812

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 13 WARD)

2-FULL NAME Mr. George Stewart Johnson

(a) RESIDENCE No. 2101 Bolton ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Goods business

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. A. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Emma Stewart

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania
(State or country)

14 Informant Mrs. Emma Johnson
(Address) 2101 Bolton St

15 Filed ....., 19.... Robert P. Harris Registrar

AUG 28 1924

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1924

17

I HEREBY CERTIFY, That I attended deceased from August 19, 1924, to August 27, 1924

that I last saw him alive on August 27, 1924

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Myeloid leukaemia

..... (duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Donald C. Handler, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Aug 29 1924

20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89813

CERTIFICATE OF DEATH.

188-003 D 89813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Day

(a) RESIDENCE NO. 511 Little Forrest St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Elizabeth Burn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Day
(Address) 511 S. Forrest St

15 Filed AUG 29 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Struck by Auto

(duration) yrs. mos. — ds.

(Signed) W K Fennell, M. D.
(Coroner.)

8/28, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 30 1924

20 UNDERTAKER John H. Trader — ADDRESS 1027 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE that it may be properly classified. CAUSE OF DEATH in plain terms, so that i TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

174093
D 89814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Charles Breeden

(a) RESIDENCE NO. 1616 E Hamond ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 22-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Breeden

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Anna Blunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant (Address) Record Johns Hopkins Hospital

15 Filed AUG 29 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1924 to Aug 25 1924 that I last saw him alive on Aug 25, 1924, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) [illegible] M. D.

19 ... Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 29, 1924
20 UNDERTAKER	ADDRESS
A. Howard Evans	386 E. Fordham

Spec.—1-10-21—M&T—1500 Bks.

D 89815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89815

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 Braddish Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emile F. A Cheramie

(a) RESIDENCE NO. 1638 Braddish Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emilie

6 DATE OF BIRTH (month, day, and year) Sept 7 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sr. Mc Cut

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Emile Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Emile Kuhn

12 MAIDEN NAME OF MOTHER Emile Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emile Kuhn

14 Informant Mrs Emilie Cheramie (Address) 1638 Braddish Ave

15 Filed ....., 19 ..... Registrar

AUG 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. , 1921 , to Aug. , 1924 ,

that I last saw him alive on Aug. 27 , 1924

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Metastatic Recurrence of Carcinoma of Rectum

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

8/29/1924 (Address) 3014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 29 1924

20 UNDERTAKER Wm Carter

ADDRESS 502 E. N. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89816 ✓ D 89816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 N. Fremont St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Clinton Heisen

(a) Residence No. 707 N. Fremont St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Cross Heisen

6-DATE OF BIRTH (month, day and year) June 6, 1869

7-AGE, 55 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer) Police 061

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Henry Heisen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) James Heisen

(Address) 707 N. Fremont

15- Filed..... 192.....

Registrar.

AUG 2 0 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 9, 1924 to Aug 27, 1924

that I last saw him alive on Aug. 27, 1924

and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

chronic nephritis; hemiplegia from cerebral hemorrhage Sept 15, 1915 again Mar. 22, 1921 again Aug 6, 1924

about 9
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) pulmonary edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Kupp M. D.

Aug 28, 1924 (Address) 1002 W. Conway St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Aug 29, 1924
20-UNDERTAKER, Wm Cook	ADDRESS Solemn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39817

CERTIFICATE OF DEATH.

31 D 39817

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Ave near 3rd. St.) WARD 25

2-FULL NAME Gertrude A. Kelsall.

(a) RESIDENCE No. Franklin Ave near 3rd. St. Brooklyn WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Kelsall.

6 DATE OF BIRTH (month, day, and year) November 19, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Louis Bloyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Fannie Fries.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Joseph Kelsall (husband)
(Address) Franklin Ave near 3rd. St. Brooklyn.

15 Filed AUG 29 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.
Acute dilatation of the Heart and
Oedema of the Lungs.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Aug. 27, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tranaients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill 9266	Aug 30 1924

20 UNDERTAKER Wm. Cook ADDRESS 502 E North Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

89818 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89818

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1015 Plum al St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Delia Johnson

(a) Residence No. 1015 Plum al St. 23 Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE. Col.

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) 1879

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). General

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Peter Thayer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Rhoda Hopkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-Informant. Georgiana Williams

(Address). 1015 Plum al

15-Filed AUG 29 1924 H. Ahl Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 21 19 24 to Aug 26 19 24

that I last saw h.. alive on Aug 26 19 24

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Alcoholism Toxitis

Acut (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Thos Burke, M. D.

Aug 29, 19 (Address) 908 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. Aug 29 19 24

20-UNDERTAKER. Frank L. Brown & Son ADDRESS 107 W Monty.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89819

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Warren

(a) Residence No. 1109 Low St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE.	If LESS than 1 day
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Adam Warren

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- Filed Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-25-24

17- I HEREBY CERTIFY, That I attended deceased from 8-23 1924 to 8-25 1924

that I last saw h— alive on 8-25 1924

and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. ?? ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude B. Broad, M. D.

8-25. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER. ADDRESS

(Commissioner Health.

Per. Wm. R. WOODALL

AUG 20 1924 Burial Permit 1728 Clerk

AUG 26 1924

UNIVERSITY OF MARYLAND

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89820

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1602 Eastern ave ST., 3 WARD)

2-FULL NAME Annie Tillison Johnson

(a) RESIDENCE NO 1602 Eastern ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Johnson

6 DATE OF BIRTH (month, day, and year) X

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer Herself 04

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Horace Tillison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) maryland

14 Informant Stella Jackson
(Address) 1735 Carlton St

15 Filed Aug 29 1924 Robert F. Garrison, Registrar
Burial Permit Issued, Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cut Dilatation

Heart (duration) 3 years yrs. mos. ds.

(Signed) James M Kenton, M. D.
(Coroner.)

Aug 27, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	192
20 UNDERTAKER Commissioner of Health,	ADDRESS AUG 29 1924

Per. Wm. F. WENDELL

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, HOURS or MINUTES must be given. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89821

CERTIFICATE OF DEATH.

D 89821

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sefton Ave nr Westfield St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen Eugene Hopper

(a) Residence No. Sefton Ave nr Westfield Ave St., 27 Ward.....
(Usual place of above)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Hopper

6-DATE OF BIRTH (month, day and year) March 4-1873

7-AGE. 51 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Chemical Mfg

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank Hopper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland Queen Georges Co.

12-MAIDEN NAME OF MOTHER, Mary Kernan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Annie L Hopper

(Address) Hamilton Balto Md

15- AUG 29 1924 Robert P. Harrison, 192..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 29/24

17- I HEREBY CERTIFY, That I attended deceased from Janu 23 1924 to Aug 29 1924 that I last saw him alive on Aug 28 1924 and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 1 yr. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Morris B. Green M. D.

Aug 29 1924 (Address) Hamilton Balto Maryland

State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Forest Cathedral

DATE OF BURIAL, Sept 1 1924

20-UNDERTAKER Leonard J. Quick

Address McField ave Hamilton Md

*—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. should be stated in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89822 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 89822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1200 West Mosher St. 16 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Susannah Westernberger

(a) Residence No. 1200 West Mosher St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William George Westernberger

6-DATE OF BIRTH (month, day and year) May 22, 1849

7-AGE, 75 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER John N. Mackenheimer

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eleanora McKewen

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs. Margaret Williams

(Address) 1200 W. Mosher St.

15- Filed ....., 192.....

Registrar.

AUG 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 11 24 to Aug 27 24, that I last saw h.. alive on Aug 28 24, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Stomach Bowel dem

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Davis, M. D.

8-28-24 (Address) 3108 Brookfield Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Union Park Cemetery	Aug 30 '24
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 N. Balto St

B.—WRITE PLAINLY, WITH UNFADING INK. should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. instructions on back of certificate.

ted EXACTLY. PHYSICIANS should state CAUSE OF DEATH ified. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 89823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt. general Hospital

CITY OF BALTIMORE: (No. Rayner Ave & Dulaney ST., 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret A Henshaw

(a) RESIDENCE NO. 1828 W. Lanvale ST., — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Henshaw.

6 DATE OF BIRTH (month, day, and year) July 17-1864

7 AGE 60 yrs	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. t mary's Co. Md.

PARENTS

10 NAME OF FATHER Joseph A Abell

11 BIRTHPLACE OF FATHER (city or town) (State or country) St marys Co. Md.

12 MAIDEN NAME OF MOTHER Jane Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. marys Co Md.

14 Informant Joseph A. Abell
(Address) 3127 Wilkens Avenue

15 Filed AUG 29 1924, 19.....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/24 1924

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to Aug. 27, 1924, that I last saw her alive on Aug 27, 1924, and that death occurred, on the date stated above, at 10:50 A m.

The CAUSE OF DEATH* was as follows:

A- Leukemic Leukemia.

(duration) 1 yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of 7/21/24.

Was there an autopsy? no

What test confirmed diagnosis? clinical & operative

(Signed) Clement R. Monroe. M. D.

8-28 1924 (Address) West Balt. general Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 30, 1924
20 UNDERTAKER Joseph B. Cook	ADDRESS 1603 N Gilmor St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89824

CERTIFICATE OF DEATH.

+/85 89824

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. University Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sadlek

(a) RESIDENCE NO Laurel Md ST., WARD Laurel Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John F. Sadlek

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josephine Foresid

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant John F. Sadlek
(Address) Laurel Md

15 Filed ....., 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or~~ inquiry.) find that said deceased came to Came death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest & Internal injuries
a few hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Drowning Washing machine over a bucket which he was on for an unknown yrs. mos. ds.

(Signed) W. X. Forrest, M. D.
(Coroner.)

8/29, 1924 (Address) 111 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	Aug 30 192 4
20 UNDERTAKER	ADDRESS
Geo E French	Laurel Md

mation should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 89825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89825

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3414 Springdale St. 45 WARD)

2-FULL NAME Esther Emanuel

(a) RESIDENCE. NO. 3414 Springdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 30 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Leb. Emanuel.

6 DATE OF BIRTH (month, day, and year) [illegible] 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66		0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Koenigsberg Prussia.

PARENTS

10 NAME OF FATHER Harry Schapiro.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Esther Schapiro.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14 Informant Minna Emanuel (Address) 3414 Springdale ave

Filed AUG 29 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1924, to Aug. 29, 1924, that I last saw h.. alive on Aug 28, 1924, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

① Diabetes Mellitus.

② Diabetic Coma.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No. —

What test confirmed diagnosis? — —

(Signed) Chas. S. Nanstadt, M. D.

8/29/24 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Retreat Southern ave DATE OF BURIAL 8/29 1924

20 UNDERTAKER Sol. Levinson & Bro ADDRESS 1127 E. Baltimore St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39826

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 936 W Lombard St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Richard F Dolan

(a) Residence No. 936 W Lombard St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 5 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 1894

7-AGE. 30 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) D 23

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Pete Dolan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Burke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland.

14- (Informant) Mr Mary Dolan

(Address) 936 W Lombard St

15- AUG 29 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 28th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1924 to Aug 27 1924

that I last saw h.. alive on Aug 27 1924

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ● Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Cahn M. D.

, 19 (Address) 2105 W Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Sept 3 1924

20-UNDERTAKER. Edward F Cowan & Son — ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 39827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39827

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Arlington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret F. Shea

(a) RESIDENCE NO. 426 N. Arlington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Jan 2-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
4	28	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Larkner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Bridget Shea 426 N. Arlington Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Burial Permit Cl...

AUG 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 26. 1919, to Aug 28. 1924, that I last saw her alive on Aug 27. 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. 4 mos 2 ds.

CONTRIBUTORY (Secondary): None

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Examination

(Signed) Henry C. Oake, M. D.

Aug 27 1924 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 30 1924
20 UNDERTAKER	**ADDRESS**
John J. Keenan & Son	901 Hollins St
Per J. J. Keenan	

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Spec.—1-10-21—M&T—1500 Bks.

D 89828

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89828

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 Guilford Ter. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Della Potter Griffith

(a) RESIDENCE No. 3423 Guilford Ter. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac S. Griffith

6 DATE OF BIRTH (month, day, and year) Jan 5-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46 yrs.	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER John Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset County Md

12 MAIDEN NAME OF MOTHER Sara Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset County Md

14 Informant Mrs. William Potter

(Address) Pennsylvania Ave. Balto Co

Robert P. Harrison,

Burial Permit Clerk.

AUG 29 1924 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8 . 1924 to Aug 28 . 1924

that I last saw her alive on Aug 28 . 1924

and that death occurred, on the date stated above, at 8 30 A. P. m.

The CAUSE OF DEATH* was as follows:

Lethargic encephalitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer L. Wood, M. D.

8/29 . 1924 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept 1 1924
20 UNDERTAKER	ADDRESS
Holmes & Son	805 N. Calvert St

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89829

CERTIFICATE OF DEATH.

X 129 D 89829

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 Eichman Ave ST., 8 WARD)

2-FULL NAME Geo. Francis Pickering

(a) RESIDENCE No. Bartholow Road. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6- 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Pickering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dorothy Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Emanuel Pickering

(Address) Bartholow Road

15 Filed AUG 29 1924, 19 Robert P. Harrison Registrar

Burial Permit 6...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 28. 24 19

17 I HEREBY CERTIFY, That I attended deceased from 8. 5. 24, 19, to 8. 28. 24, 19,

that I last saw h alive on 8. 28. 24, 19,

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical + micro + chemical tests

(Signed) O.B. Towler, M. D.

8.29.24, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL 8-31-24

20 UNDERTAKER Robt Bennett ADDRESS 1432 William St

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89830

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 89830

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. 118-092

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Alice Della Thorn

(a) RESIDENCE No. Weaver W. Va ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER Robert Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Va.

12 MAIDEN NAME OF MOTHER Catherine Corley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant: Record
(Address) Johns Hopkins Hospital

15 Robert P. Harrison, Registrar

AUG 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1924, to Aug 29, 1924, that I last saw h.. alive on Aug 29, 1924, and that death occurred, on the date stated above, at 2 10 A. m.

The CAUSE OF DEATH* was as follows:

Paralytic ileus

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myoma uteri, Endometrial polyp (duration) Unknown yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Weaver W Va.

Did an operation precede death? Yes Date of Aug 25, 24

Was there an autopsy? No

What test confirmed diagnosis? Anoperation

(Signed) Richard W. Tetlow M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkersburg W Va	Aug 29 1924
20 UNDERTAKER	ADDRESS
Joseph Adrey	221 Ruff

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89831

CERTIFICATE OF DEATH.

D 89831

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) Residence No. 211 Rock st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1909

7-AGE, 15 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: school work

(b) General nature of industry, business, or establishment in which employed (or employer): Reform School

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ellie ??

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Robert P. Harris

Filed 192 Registrar.

AUG 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 28, 19 24 to Aug. 26, 19 24

that I last saw him alive on Aug. 26, 19 24,

and that death occurred, on the date stated above, at 10.25 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Disseminated tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum, X-ray

(Signed) James D. White, M. D.

8-26-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	8/30/24
UNDERTAKER	ADDRESS
David Easton	916 Pa ave

N. B.—WRITE PLAINLY, WITH INK. ... should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. ... See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89832

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 N Carlton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie Coleman

(a) RESIDENCE NO. 1231 N Carlton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ?? 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Building

(c) Name of employer: Lohmuller Bldg Co Norfolk Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: James Crosby

(Address): 1201 N Carlton St

15 Filed ..... 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 28 19 24

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 24 to Aug 28, 19 24

that I last saw h alive on Aug 26, 19 24

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Aneurysm (Abdominal)

(duration) .. yrs. .. mos — ds.

CONTRIBUTORY (Secondary)

(duration) .. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

8/28, 1924 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. V. Cemetery

DATE OF BURIAL: 8/30/24

20 UNDERTAKER: David Elliott

ADDRESS: 716 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should note mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

AUG 29 1924

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89833

CERTIFICATE OF DEATH.

38 D 89833

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

2-FULL NAME Daniel Rowley

(a) RESIDENCE NO. 1033 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ! (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed AUG 29 1924 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-5-, 1924, to 8-27, 1924, that I last saw him alive on 8-26, 1924, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Insufficiency; Myocardial Insufficiency

(duration) 1½ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Deane, M. D.

8-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Can

DATE OF BURIAL 8/30/24

20 UNDERTAKER David Earlois

ADDRESS 916 E Can

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE IS PERMANENT. PHYSICIANS should be careful in stating the AGE. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89834

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walbillick

(a) Residence No. 2022 W. Fayette St. St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Separated

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. Walbillick

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Justine Bache

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Germany

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed AUG 30 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30 19 24 to Aug. 29 19 24

that I last saw him alive on Aug. 29 19 24

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum, autopsy.

(Signed) J. S. White M. D.

8-29-, 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Sept. 1 19 24
20-UNDERTAKER.	ADDRESS
Jos. J. Herr	156 N. Luzerne

N. B.—WRITE PLAINLY, with ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 89835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89835

11-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N. Monty ST., 9 WARD)

2-FULL NAME Dr Lang Hamilton

(a) RESIDENCE NO. 1028 N. Monty ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mildred S Hamilton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber 0'14
(b) General nature of industry, business, or establishment in which employed (or employer) Phosphate Co
(c) Name of employer Grace & Monuments

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Hyman Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Rose Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant James Lockett
(Address) 1028 N. Monty

15 Filed AUG 30 1924, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28th 24

17 I HEREBY CERTIFY, That I attended deceased from August 24 19 24 to August 28 19 24
that I last saw h alive on August 28 19 24 7.45 A.M.
and that death occurred, on the date stated above, at 7.45 A.M.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) 9 yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. A. Lee Clin, M. D.
(Address) 1028 N. Monty

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elliott S C	Aug 31 1924
20 UNDERTAKER	ADDRESS
W. D. Brown's Sons	1081 N. Monty

F B R and a coast Line & Lynchburg S C

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8983 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1011 W 37 St St., 13 Ward

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Lewis Somers Jr

(a) Residence No. 1011 W 37 St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male | 4-COLOR OR RACE: White | 5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 23 1924

7-AGE. yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER John L Somers

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Carrie Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) John L Somers

(Address) 1011 W 37 St

15- Filed ..... 192 ..... Registrar.

AUG 30 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30 1924

17- I HEREBY CERTIFY, That I attended deceased from July 23 24 to Aug 30 24

that I last saw him alive on Aug 29 24

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature Gestation

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) E F Schubert M D

8/30, 1924 (Address) 1701 Riverside

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hanover | DATE OF BURIAL. Aug 30 1924

20-UNDERTAKER: CHENOWETH & SON, | ADDRESS 310 CHESTNUT AVE

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39837 D 39837

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 329 St. 30 St. (St.) 13 (Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Ledlich

(a) Residence No. 329 St. 30 St. (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Ledlich

6-DATE OF BIRTH (month, day and year) Feb 14/1851

7-AGE 73 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Street Paver

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Pauline Ledlich

(Address) 329 St. 30 St.

15- Filed AUG 30 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 28-1924

17- I HEREBY CERTIFY, That I attended deceased from July 18 1924 to Aug 28 1924

that I last saw h~~im~~ alive on Aug 28 1924

and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

with Decubitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sym

(Signed) M. Lippmann M. D

8, 29. 1924 (Address) 334 Chestnut Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL. Sept 1 1924

20-UNDERTAKER — ADDRESS

CHENOWETH & SON, FUNERAL DIRECTORS, BALTIMORE, MD.

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89838 ✓ 31 D 89838

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Mansfield Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester R Williams

(a) RESIDENCE No. 18 Mansfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) dec 18 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

050

9 BIRTHPLACE (city or town) (State or country) Warren Ind

PARENTS

10 NAME OF FATHER Benton Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Mrs Annie Williams (Address) 18 Mansfield Ave

15 AUG 30 1924 J G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to Aug 29, 1924, that I last saw h— alive on Aug 28, 1924, and that death occurred, on the date stated above, at 9. a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion from Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum —

(Signed) C N Beeler, M. D.

Aug 28 1924 (Address) 711 W Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Freelands Md DATE OF BURIAL Sept 1924

20 UNDERTAKER E LeRoy Stiffler ADDRESS 1215 North Ave

Cor.—1-12-23—M&T—100 Bks.

D 89839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. White

(a) RESIDENCE No. 1720 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Six ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Sngl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER Lucie White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant John White
(Address) 1720 McCulloh St

15 AUG 30 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus. 2 wks

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Monroe, M. D.
(Coroner.)

Aug 29, 1924 (Address) 3672 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 8/30 1924

20 UNDERTAKER Byron Wright

ADDRESS 1218 Madison Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89840

CERTIFICATE OF DEATH.

198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Bell

(a) RESIDENCE No. 759 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jas A Bell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margt Hill

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Emma Bell
(Address) 1235 W Lafayette

15 Filed....., 192 ..... Registrar

AUG 20 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wound in chest

a few minutes (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cut by Ed Markin (duration) ..... yrs. ..... mos. ..... ds.

(Signed) JJK Jewell, M. D.
(Coroner.)

8, 30, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 7, 30 1924

20 UNDERTAKER Howard Hall

ADDRESS 753 Dolphin

BEFORE filling in this certificate read carefully the instructions printed on back hereof. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89841 HEALTH DEPARTMENT—CITY OF BALTIMORE 901 D 89841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5209 Alhambra ave Ward) 74

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate V. Vogt

(a) Residence No. 5209 Alhambra Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-[redacted] Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry V. Vogt

6-DATE OF BIRTH (month, day and year) March 25th 1850

7-AGE About 74 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Charles Paine

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. J.

12-MAIDEN NAME OF MOTHER, Thankful Van Hook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. J.

14- (Informant) Harry V. Vogt

(Address) 5209 Alhambra ave

15- Filed 192 Robert P. Harrison, Registrar.

AUG 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30th 1924

17- I HEREBY CERTIFY, That I attended deceased from August 20, 1924 to August 30 1924

that I last saw h[illegible] alive on Aug 30 1924

and that death occurred, on the date stated above, at 10.55 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

High Blood Pressure

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) D. V. Grubb M. D.

Aug 30, 1924 (Address) 501 Sheridan Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Millville N. J. DATE OF BURIAL Aug 31st 1924

20-UNDERTAKER C. J. Fanning & Son ADDRESS 1938 E. Lafayette ave

White should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. D 39842

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Edward Johnson

(a) RESIDENCE NO. Rock Hall Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Belle Ada Dashiell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 Robert P. Harrison.

Registrar

AUG 31 1924 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Aug 29, 1924, that I last saw h. in alive on Aug 29, 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Acute Miliary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Rock Hall, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray - Tuberculin Test

(Signed) Thos. R. Cromwell Physician M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall, Maryland	Aug 31 1924
20 UNDERTAKER	ADDRESS 322 N. Chester St.
Mrs. Katie R. Williams	

Spec.—1-10-21—M&T—1500 Blks.

D 89843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89843

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Rayner & Lakeland ave (Bridge) ST. 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Fowler

(a) RESIDENCE No. West Minister Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs~~ ~~mos~~ 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 - 1919

7 AGE	11 Years	2 Months	8 Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) West Minister
(State or country) Md -

PARENTS

10 NAME OF FATHER Mr George Fowler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Minister Md.

12 MAIDEN NAME OF MOTHER Miss Maggie Yingling

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Minister Md -

14 Informant Mrs George Fowler -
(Address) West Minister Md

15 DG 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Aug 30, 1924, that I last saw her alive on Aug 30, 1924, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of right Ilium

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Septicemia (Staphylococcus Aureus)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug 25 1924

Was there an autopsy? No

What test confirmed diagnosis? X-Ray - Operation - Blood Culture

(Signed) Clement R. Manker, M. D.

, 19 (Address) West Baltimore General Hospital Rayner & Lakeland Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cem — DATE OF BURIAL Sept. 2 1924

20 UNDERTAKER James. M. Storer — ADDRESS Westminster Md

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. mation should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 89844 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2303 Callaur ave St., 13 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Annie Goodman

(a) Residence No. 2203 Callaur ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown 1881

7-AGE. 43 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimd

PARENTS:

10-NAME OF FATHER William Goodman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Hannah Fried

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-(Informant) Jack Lewis

(Address) 1439 E Baltost

15-Filed AUG 31 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1924 to Aug. 30 1924.

that I last saw h alive on Aug 29, 1924.

and that death occurred, on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Joseph William Kelley M. D

19 (Address) 910 Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Wash Road — DATE OF BURIAL: Aug. 31, 1924

20-UNDERTAKER: Jas T Lewis — ADDRESS: 1439 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1815 E. Fairmount Ave St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Wasserman

(a) Residence No. 1815 E Fairmount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Wasserman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dresser

(b) General nature of industry, business, or establishment in which employed (or employer) Mens Clothing

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

11- (Informant) Etta Wasserman

(Address) 1815 E Fairmount Ave

15- Filed 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 13, 1924, to Aug 29, 1924, that I last saw h.. alive on Aug 27, 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Embolism - immediate death.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) D. Clarence Cohn, M. D

, 19 (Address) 1829 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rosedale Cem

DATE OF BURIAL. 8/31, 1924

20-UNDERTAKER. Jack Levin

ADDRESS 1439 E Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G3

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89846

CERTIFICATE OF DEATH.

D 89846

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3928 Ridgewood Ave (St.) 15 (WARD)

2-FULL NAME Thomas James Walters

(a) RESIDENCE NO. 3928 Ridgewood Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide K Walters

6 DATE OF BIRTH (month, day, and year) May 3 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ticket Agent

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. 6/15

(c) Name of employer

9 BIRTHPLACE (city or town) Cardiff
(State or country) Wales

PARENTS

10 NAME OF FATHER John J. Walters

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Wales

14 Informant Mrs Adelaide K. Walters
(Address) 3928 Ridgewood Ave

15 AUG 31 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Aug 30 1924

that I last saw him alive on Aug 30 1924

and that death occurred, on the date stated above, at 12.55 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial

Nephritis (duration) Unknown yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Walter Gorrow, M. D.

8/30/24 (Address) 3 W Gaudens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington DC	Sept 2 1924
20 UNDERTAKER Wm Fickus Sons	ADDRESS North Pa

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 39847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39847

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 S Stricker St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Craycroft,

(a) Residence No. 116 S. Stricker St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7-15-1855

7-AGE. 69 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stable Boss

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: American R. Express

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Thomas Craycroft

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant) Annie J. Craycroft

(Address) 116 S. Stricker St,

15-

Filed 192 Robert P. Harrison, Registrar.

G 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29. 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 19 24 to Aug 29 19 24

that I last saw h.. alive on Aug 28 19 24

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

.....(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. W. Tupper M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Brandywine Rd

DATE OF BURIAL: Sept. 1, 1924

20-UNDERTAKER: E.LeRoy Stiffler

ADDRESS: 125 E. North Ave

EXACTLY: This Statement should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89848

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 570 Park Ave St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Blades

(a) Residence No. 570 Park Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 8 1904

7-AGE, 20 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School-Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Crisfield
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Clyde Blades

11-BIRTHPLACE OF FATHER (city or town) Crisfield
(State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Evans

13-BIRTHPLACE OF MOTHER (city or town) Crisfield
(State or Country) Md

14- (Informant) Mrs Emma Blades

(Address) Crisfield Md

15- Filed 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30 1924

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1924 to Aug 30, 1924, that I last saw h.. alive on... Aug 30, 1924, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis
Was in a Sanatorium for
Children 7 Years
(Duration) yrs. mos. 11 ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms Physical

(Signed) W Walter Wallace, M. D.

8-30, 1924 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield Md	Aug 31, 24
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N Gilmor St

Burial Permit Clerk

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

G 3

Spec—12-23-21—E.B.R.S.—500 Blks.

D 89849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 31

City of BALTIMORE: (No. Municipal Tuberculosis St. Ward)

2-FULL NAME Alias Charles Howard Randall Griffith

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Leaving House St., City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown 1856

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George Griffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Mary Carpender

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Hospital Records

(Address) M. P. H.

15- Robert P. J. Harrison, Registrar.

G3 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 29 1:45 P.M. to Aug. 29 8:50 P.M. 19 24

that I last saw him alive on Aug. 29 19 24

and that death occurred, on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Terminal Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) J. S. Blake M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Olivet Cem	Sept 1st 24
20-UNDERTAKER	ADDRESS
Joseph B Cook	1003 N Gilmor St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 15 WARD)

REGISTERED NO. 1886

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna C. Shannon

(a) RESIDENCE NO. 4314 Penhurst ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1913 (guess)

7 AGE — Years: 11 | Months: 4 | Days: 25 | (If LESS than 1 day, ... hrs. or ..... min.)

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Edward Shannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Katherine Ketchum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Fred Ketchum (Address) 4314 Penhurst Ave

Filed AUG 31 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

few minutes (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) automobile accident (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Aug. 30, 1924 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 8/1 1924

20 UNDERTAKER: Henry W. Jenkins Sons

ADDRESS: Orchard & McCulloh

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH is very important.

Cor.—1-12-23—M&T—100 Bks.

D 89851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89851

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., ... WARD)

2-FULL NAME Susan Hollenberg

(a) RESIDENCE NO. Union Town, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha Hollenberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Carroll Co Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant C. Frost
(Address) Glenwood Md

15 Filed AUG 31 1924. Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Morrison, M. D.
(Coroner.)

Aug 30 1924 (Address) 763 Poplar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Uniontown Md	Sept 1 1924
20 UNDERTAKER W M Routson	ADDRESS 2238 Mitt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 31 1924

Spec.—1-10-21 M&T 1500 Blks.

D 89852

HEALTH DEPARTMENT—CITY OF BALTIMORE

89852

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 Ash St., ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura F. Jones

(a) RESIDENCE NO. 3422 Ash St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel Maryland

PARENTS

10 NAME OF FATHER Charles R. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Tabitha A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Frances Ly. Jones

(Address) 3422 Ash St.

15 Filed ..... 19 Robert P. Harrison, Registrar

AUG 31 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Aug 30, 1924, that I last saw h[er] alive on Aug 27, 1924, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) C & A nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. F. Campbell M. D.

Aug 30 1924 (Address) 3701 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Mary's Hampden	Sept. 1 1924
20 UNDERTAKER Horace F. Burgee	ADDRESS 363 Hall Pl

N. B.—WRITE PLAINLY. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are urged CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89853

CERTIFICATE OF DEATH.

REGISTERED NO. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Maryland ave ST., 25 WARD)

2-FULL NAME Mary S. Steinmacker

(a) RESIDENCE NO. 9 Maryland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Steinmacker

6 DATE OF BIRTH (month, day, and year) 66

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	1858	January	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home mkr

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Demling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Seidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jno Steinmacker 9 Maryland ave & Balto

15 Filed Robert P. Harrison, Registrar

AUG 31 1924 Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-26, 1924, to 8-29, 1924.

that I last saw her alive on 8-29, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

acute indigestion

chronic interstitial nephritis

Arteriosclerotic Heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W B Ball, M. D.

, 19 (Address) Hilltop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park — DATE OF BURIAL 8/31 1924

20 UNDERTAKER John J Fields — ADDRESS Gilmor & Lombard

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39854

CERTIFICATE OF DEATH.

24 X 188-93 39854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arbutus Anderson. (C)

(a) RESIDENCE NO. Annapolis Blvd. Morris Hill A. A. Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos.--- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 14, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Martin Anderson. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Daisy Brooks. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Martin Anderson. (C) father.
(Address) Annapolis Blvd. Morris Hill A.

15 Filed G 3 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not sufficient. If from violence, state whether Accidental, Suicidal or Homicidal. If from accident, state whether Occupational. If from suicide, state whether committed while insane or sane. If from homicide, state whether murder or manslaughter. If from casualty

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89855

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1720 E Lafayette Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Welsh

(a) Residence No. 1720 E Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1849

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer Pattern M

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas Welsh

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Flaherty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Miss Delia Welsh

(Address) 1720 E. Lafayette Ave.

15- Filed Sept 1 1924 Robert P. Harrison, Burial Permit Clerk. Registrar.

P1 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 28th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1924 to Aug 28 1924

that I last saw h. alive on Aug 27 10 P.M. 1924

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

few hours

Arteriosclerosis

(Duration) yrs. mos. ds. some years

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? all

(Signed) W. S. Tilley M. D.

, 19 (Address) 1639 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Sept 1st 1924
20-UNDERTAKER.	ADDRESS
E. J. Fanning Inc - 1938 E Lafayette Ave.	

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89856

CERTIFICATE OF DEATH.

118-102

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St Joseph Hospital (ST.) (WARD)

2-FULL NAME Louis C. Bushman

(a) RESIDENCE No. 1140 Ballery ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Bushman

6 DATE OF BIRTH (month, day, and year) April 1-1850

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bal Md
(State or country)

PARENTS

10 NAME OF FATHER H. Middendorf

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Bukenmeyer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Record
(Address)

15 Filed SEP 1 1924, 192 Robert B. Harrison, Burial Permit Clerk.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

CAUSE OF DEATH* was as follows: Robert Bushman

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... , M. D.
(Coroner.)

Aug 30 1924 (Address) 3622 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co.	9-1 1924
20 UNDERTAKER	ADDRESS
E + B Hasle 115	E West St

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 89857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Patterson Park ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Mueller

(a) RESIDENCE NO 1064 N Maryland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Mueller

6 DATE OF BIRTH (month, day, and year) Nov 10th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Edw Mueller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Albine Baumgarten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Schultz
(Address) 704 N Bond Ave

Filed SEP 1 1924 192 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bullet Wound in Abdomen Self Inflicted
Suicide while insane

(duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(duration) yrs. mos. ds.

(Signed) James M Hanlon, M. D.
(Coroner.)
Aug 30, 1924 (Address) 702 E Clay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 9/2 1924

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1748 89858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89858

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ziegler

(a) RESIDENCE No 2004 E Lombard St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: George Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Katie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant

(Address JOHNS HOPKINS HOSPITAL)

15 Filed SEP 1 1924, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1924, to Aug 30, 1924, that I last saw her alive on Aug 30, 1924, and that death occurred, on the date stated above, at 4 10 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) & vomiting

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edward H. Kemper, M. D.

Aug 31, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL 9/1/24

20 UNDERTAKER: John Ellis — ADDRESS 220 E Eden

NOTE.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89859

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1912 Mt Royal Terrace Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Rachael Stuart

(a) Residence No. 1912 Mt Royal Terrace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of David T Stuart

6-DATE OF BIRTH (month, day and year) Feby 3 1827

7-AGE. 97 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Howard Co Md

PARENTS.

10-NAME OF FATHER. Nelson P. Stuart

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ann Card

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) C. Thos. Stuart

(Address) 3216 Auchentoroly Ter

15- Filed SEP 1 - 1924 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 27th 1924 to Aug 29th 1924

that I last saw h.e alive on Aug 29th 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 51 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stephen F. Steinmann M. D.

, 19 (Address) 6 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Sept 1 1924

20-UNDERTAKER. John O. Mitchell — ADDRESS 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. Information under OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89860

CERTIFICATE OF DEATH.

160 / D 89860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 N Eutaw ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Thomas Jr

(a) RESIDENCE NO. 1020 N. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-24

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Blue Ford Co Md

14 Informant (Address): Mary Thomas 1020 N Eutaw St

15 Filed SEP 1 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1924, to Aug 29 1924, that I last saw him alive on Aug 29 1924, and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage by Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Colmus M. D.

19 24 (Address) 2037 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 2 24

20 UNDERTAKER: Samuel L Hemsley — ADDRESS: 1317 Bank

N. B.—WRITE LEGIBLY. PENCIL WRITING CANNOT BE READ. Information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 39861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39861

CERTIFICATE OF DEATH.

174-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Bay View Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Woodland, Mary Frances

(a) Residence No. 1712 Division St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col.

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or ~~divorced~~ ~~(HUSBAND of ~~)~~ WIFE of Woodland, John

6-DATE OF BIRTH (month, day and year) ? ? 1877

7-AGE, 47 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress.

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer ←

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town)..? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..? (State or Country),

14- (Informant) John Woodland (husband)

(Address) 1712 Division St.

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

SEP 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 29-

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Aug 29, 1924.

That I last saw her alive on Aug 26, 1924.

and that death occurred, on the date stated above, at 8 40 ~~P~~ a.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 6 ds.

18-Where was disease contracted if not at place of death? ←

Did an operation precede death? no Date of ←

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) N. F. Edmunds M. D.

, 19 (Address) Maryview Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. B & O Tel. Co. | DATE OF BURIAL. Sept 2 24

20-UNDERTAKER. Samuel Walmsley | ADDRESS 1238 N Bradd

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89862

CERTIFICATE OF DEATH.

113 ✓ D 89862

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1619 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda C. Jordan

(a) RESIDENCE NO. 1619 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Jan. 1924~~

6 DATE OF BIRTH (month, day, and year): Jan. 1924

7 AGE — Years: — Months: 8 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry C. Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mary Boyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs. Jordan

(Address): 1619 Division St.

15 Filed SEP 1 1924 ROBERT F. MATTISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19th 1924 to Aug. 30th 1924

that I last saw h alive on Aug 30th 1924

and that death occurred, on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pott's Endocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elder M. D.

, 19 (Address) 422 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Sept 2 24

UNDERTAKER: Samuel J. Hunsley — ADDRESS: 18 N Bridge

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 89863

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 Maryland Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Smith

(a) Residence No. 1103 Maryland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alice T. Smith

6-DATE OF BIRTH (month, day and year) Feb. 9-1865

7-AGE.	If LESS than 1 day,
59 yrs. 6 mns. 20 ds.	....hrs. nr....mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Maryland
(State or Country).

PARENTS.

10-NAME OF FATHER, Robert Smith

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).

12-MAIDEN NAME OF MOTHER, Frances Brown

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country).

11-

(Informant) Alice T. Smith

(Address) 1103 Maryland Ave

15-

Filed SEP 1 1924 19.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 19 24 to Aug 29, 19 24

that I last saw h.. alive on Aug 27 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY Unknown
(Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) A. K. Pettetavin M. D.

, 19 (Address) 817 Hamilton Ter.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ..., 19 24
20-UNDERTAKER, Frank Kennedy	ADDRESS 1728 N Bdde

should be carefully supplied. AGE should be stated EXACTLY. Name of OCCUPATION is very important, and should be clearly classified. Exact statement of OCCUPATION is very important, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89864 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. ST., 16 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Collett

(a) RESIDENCE NO. 1815 Oakley St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Apr. 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles F. Collett

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Vollmer

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Charles F. Collett
(Address) 1815 Oakley St

15 Filed SEP 1 1924 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st. Third degree burns of body.

Homicidal. Placenta

of under (duration) ..... yrs. ..... mos. 1/2 hr.

CONTRIBUTORY (Secondary) Gas stove by demented mother

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Aug. 31, 1924 (Address) 200 Clarendon Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Sept. 1 192

20 UNDERTAKER Mrs. & Mrs. J. W. Teufel & Son ADDRESS 801 W. Faye

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89865

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 W. Fayette St. ST. 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian F. Oppenheimer

(a) RESIDENCE NO. 2202 W. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel Oppenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Isabelle Lowenthal

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. Samuel Oppenheimer (Address) 2202 W. Fayette St.

15 Filed SEP 1 1924, 19 Albert F. Harrison, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/24. 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Aug 30, 1924, that I last saw h er alive on Aug 30, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X ray.

(Signed) Chas A Cahn, M. D.

8/30. 1924 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: 9/1/24 19

20 UNDERTAKER: Darrd Sondheim ADDRESS 115-20 W. Mt. Royal Ave

4. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. Exact statement of OC PA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec--12-23-21—E.B.R.S.—400 Bks.

D 89866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89866

CERTIFICATE OF DEATH.

9 74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1024 E. North Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Ward

(a) Residence No. 1024 E. North Ave St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 4-1856

7-AGE 67 yrs. 4 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Ward

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Dennis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Chas. Gammie

(Address) 1027 E. North Ave

15- Filed ..... 19.. Robert P. Harrison, Registrar.

EP 1 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/31/24

17- I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to Aug. 31, 1924, that I last saw h.r alive on Aug. 31, 1924, and that death occurred, on the date stated above, at 1.9 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chr.
Myocard Dis. Central
Nervous Syst.

(Duration) 3 + yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dila-
tation (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Harry Clyde, M. D.

Aug. 31 19 24 (Address) 1024 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Sept. 2. 1924

20-UNDERTAKER, H. E. Wiedefeld — ADDRESS 914 Greenmount Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. (Sarah Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89867

CERTIFICATE OF DEATH.

129

D 89867

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 E Belvidere St. Ward) 3

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah Smith

(a) RESIDENCE. No. 305 E Belvidere St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 6 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Estella Sinclair (Address) 305 E. Belvidere

15 Filed . 19 Robert P. Harrison, Registrar

SEP 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 . 1924 . to Aug 24 . 1924 that I last saw h alive on Aug 24 . 1924 and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Brights Disease.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. McLaury, M. D.

. 19 (Address) 1303 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 1 1924

20 UNDERTAKER Mrs R. G. Elliott ADDRESS 1205 Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. Information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificate. OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 89868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89868

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 5th Ave Roynel Heights WARD) 28

2-FULL NAME Grace A O'Brien

(a) RESIDENCE NO. 701 5th Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F O'Brien

6 DATE OF BIRTH (month, day, and year) Feb 22 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Skelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Wm Hearn

(Address) 701 5th Ave

15 SEP 1 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-4, 1924, to 8-28-, 1924, that I last saw her alive on 8-28-, 1924 and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Helen Hennessy M. D.

9/6, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loth Cem	9/2 1924

20 UNDERTAKER Boyle Farley Fulton & Jayne ADDRESS

N B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

89869

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 89869

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1110 Somerset ST., 10 WARD)

2-FULL NAME Wilhelmina Schisler

(a) RESIDENCE NO. 1110 Somerset ST., 10 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) April 17 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Schisler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Crecentia Brauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles Schisler

(Address) c/o Somerset

15 Filed APR 1 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Aug 31, 1924, that I last saw her alive on Aug 31, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Parenchymatous Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D.

(Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 3rd 1924
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager St

FEB.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. All information should be carefully supplied. Exact statement of OCCUPATION of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89870

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Goldfinger

(a) RESIDENCE NO. 103 S. Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Goldfinger

6 DATE OF BIRTH (month, day, and year) ? 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Perelstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Grinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1409 E Balto

15 Filed 9/4 1924 Robert P. Harrison Registrar

P 1 - 1324

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Sept 1, 1924,

that I last saw her alive on Sept 1, 1924

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Silas Jarboe, M. D.

9/1, 1924 (Address) Hebrew Apts Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 9/1 1924

20 UNDERTAKER Jack Lewis 1409 E Balto — ADDRESS

P. S.—WRITE PLAINLY. PENCIL should be carefully supplied. AGE should be stated EXACTLY. Fractions of a day should be given in hours and minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39871 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 39871

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 1112 S. East Ave St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman R. L. Minde

(a) Residence No. 1112 S. East ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Minde

6-DATE OF BIRTH (month, day and year) March 10-1846

7-AGE.	If LESS than 1 day,
78 yrs. 5 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Robt. Minde

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Laura Minde

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Caroline Minde

(Address) 1112 S. East ave

15-

Filed SEP 1 - 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 31-1924

17- I HEREBY CERTIFY, That I attended deceased from June 10 19 24 to Aug. 31 19 24

that I last saw h[illegible]ive on Aug. 31 19 24

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry B. Kelly M. D.

9/1, 19 24 (Address) 2504 St Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western	Sept 3 1924
20-UNDERTAKER,	ADDRESS
Zirkler & Zirkler	1734 Eager

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39872

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1814 Gough St., ✓ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D. Kiely

(a) Residence No. 1814 Gough St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 4-1843

7-AGE. 81 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John W. Kiely

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER, Jennette Wonham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant) Mary J. Cuckley

(Address) 1814 Gough St.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

SEPT - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 29. 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug-22 19.24 to Aug-29 19.24

that I last saw h— alive on Aug 29 19.24

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Coma —

(Duration) ....yrs. ....mos. 6 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jno. C. Broadbent M. D

Aug 31, 1924 (Address) 125 E Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 2, 1924
20-UNDERTAKER, Finkler & Finkler	ADDRESS 1734 Eager

should be carefully supplied. AGE should be stated EXACTLY. If unknown it may be approximated. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89873

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1116 Sexton ST., 25 WARD)

2-FULL NAME Jr. Henry Riley

(a) RESIDENCE No. 1116 Sexton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Riley

6 DATE OF BIRTH (month, day, and year) Aug 12/1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	—	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Flange Turner
(b) General nature of industry, business, or establishment in which employed (or employer) B&O RR
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Riley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Holland
(State or country)

14 Informant Mrs. Katie Riley
(Address) 1116 Sexton St

15 Filed SEP 1 1924, 192

Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

(Duration) about 24 hrs mos ds.

CONTRIBUTORY (Secondary) Shock Suffd with pneumonia

(Duration) yrs. mos. ds.

(Signed) Chas. B. Norton, M. D.
(Coroner.)

Aug 31st, 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Sept. 2, 1924

20 UNDERTAKER George L. Schwab — ADDRESS 101 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact nature of disease is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 89874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89874

CERTIFICATE OF DEATH.

162

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Maternity ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gloria annette Sweeney

(Residence in Baltimore: No. 436 Whitridge St.; .....yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	W	Sing'l

6-DATE OF BIRTH, aug. 27, (Month) (Day) 1924 (Year)

7-AGE.	If LESS than 1 day,
.....yrs. .....mos. 4 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER. Francis X Sweeney

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Anne Porock

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sweeney

(Address) 436 Whitridge Ave

15- Robert P. Harrison,

SEPT - 1924 101..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, aug. (Month) 31 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from aug 27 1924, to aug 31 1924, that I saw her alive on aug 31 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Breech Presentation

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Intracranial Pressure

..... (Duration).....yrs.....mos.....ds.

(Signed) Lyman D. Gibbs M. D.

....., 191... (Address) 1832 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 4 ds. In the State .....yrs. .....mos. 4 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 436 Whitridge ave.

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem DATE OF BURIAL, 9-1-....., 1924

20-UNDERTAKER Robert Brooks & Son ADDRESS Calhoun & Hollins sts

Every item of information should be carefully applied. Exact statement of OCCUPATION is important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1724 N. Pond St., 9 Ward) 113 Registered No.

2-FULL NAME Beatrice E Bart

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1724 N. Pond St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 28 - 1923

7-AGE, 1 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles W. Bart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER, Dorothy V. Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Phila Pa

14- (Informant) Chas. W. Bart

(Address) 1724 N. Pond

15- Filed Aug 30 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 29-1924

17- I HEREBY CERTIFY, That I attended deceased from 8-25, 1924, to 8-29, 1924, that I last saw h.. alive on 8-29, 1924, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pleo Colitis

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an antopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dame Miller, M. D.

, 19 (Address) 1500 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Pk. DATE OF BURIAL, Sept 1, 1924

20-UNDERTAKER, Robt E Turner & Son ADDRESS 4 E Fayette

should be carefully supplied. AGE should be stated EXACTLY. PROFESSION or OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 89876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89876

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1420 E. Fairmount St., 5e WARD)

2-FULL NAME Frank Johnson

(a) RESIDENCE No. 1420 Fairmount St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 68 | Months - | Days - | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co. Md.

PARENTS

10 NAME OF FATHER: Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rosetta Sudler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Willie Wilson
(Address) 401 Watson St.

15 Filed Aug 31 1924, 192

Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaboular
Diseases of
Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Emerson, M. D.
(Coroner.)

Aug 31, 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Sept 1 1924

20 UNDERTAKER

ADDRESS: R C Grass 211 Pine St

Aug 31 1924

Registrar's attention is directly called to the following: Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89877

CERTIFICATE OF DEATH.

44

D 89877

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 442 E Cross ST., 24 WARD)

2-FULL NAME Annie R Edwards

(a) RESIDENCE NO. 442 E Cross ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of John T. Edwards

6 DATE OF BIRTH (month, day, and year) Jan 26, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. Bunke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Julia Cates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Mrs. Bayne

(Address) 442 E. Cross St

15 Filed ....., 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/24

17 I HEREBY CERTIFY, That I attended deceased from Jan 2/24, 19..... to Aug 29/24, 19.....

that I last saw h.. alive on Aug 29/24, 19.....

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

.....(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Thos D Ward, M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem.

DATE OF BURIAL Sep. 1, 1924

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

SEP - 1924

GE should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89878

CERTIFICATE OF DEATH.

14 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Slack

(a) Residence No. 1528 Johns St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, married Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Nelson

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 69 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Elite Laundry Co. 608

9-BIRTHPLACE (City or town)..... (State or Country) Md

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Do not know

11- (Informant) A. William Field

(Address) Elite Laundry Baltimore

15- Filed 9/2 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

P 1

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/31/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1924 to Aug 31st 1924 that I last saw him alive on Aug 31st 1924 and that death occurred, on the date stated above, at 5.50 A m. The CAUSE OF DEATH* was as follows:

Myocardial failure

(Duration) ....yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Enteritis

(Duration) 2 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. F. Deane M. D

, 19 (Address) 1 Mon Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL. 9/2 1924

20-UNDERTAKER. Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89879

CERTIFICATE OF DEATH.

57 D 89879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 15 S...C... WARD)

2-FULL NAME Mrs. Eva S Sheild

(a) RESIDENCE NO. 1720 N. Appleton WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J Sheild

6 DATE OF BIRTH (month, day, and year) Dec 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	67	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: James R Fulford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Rosena M Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hospital Record (Address)

15 Filed ..., 19 Robert P. Harrison, Registrar

SEP 1 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/24

17 I HEREBY CERTIFY, That I attended deceased from 8/27/24, 19.. to 8/29/24, 19.. that I last saw her alive on 8/29/24, 19.. and that death occurred, on the date stated above, at 8:35 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Arterio Sclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Sept 1 1924

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1741 89880

HEALTH DEPARTMENT—CITY OF BALTIMORE

1741 89880

CERTIFICATE OF DEATH. X 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME John Dougherty

(a) RESIDENCE NO. 79 Donnadale Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Dougherty

6 DATE OF BIRTH (month, day, and year): Oct 9-1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 [illegible] 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 18 , 1924, to Aug 30 , 1924, that I last saw him alive on Aug 30 , 1924, and that death occurred, on the date stated above, at 6 00 p. m.

The CAUSE OF DEATH* was as follows:

Aortic stenosis and insufficiency

Auricular fibrillation

Myocardial insufficiency

Pleural effusion (duration) 0 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Office

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autop

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 2 1924

20 UNDERTAKER: Wm Cook & — ADDRESS: 502 E Nott

Burial Permit Clerk

P 1

B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 39881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 39881

REGISTERED NO. 129

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Reynor & Dukeland ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Susanna Horner -

(a) RESIDENCE No. 2403 Oswego ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/23/1843.

7 AGE	81 Years	3 Months	8 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Trenton
(State or country) new Jersey

PARENTS

10 NAME OF FATHER Mr. Carter

11 BIRTHPLACE OF FATHER (city or town) Bucks
(State or country) County Pa.

12 MAIDEN NAME OF MOTHER Rebecca Hibbs

13 BIRTHPLACE OF MOTHER (city or town) Bucks
(State or country) County Pa.

14 Informant E F Stevens
(Address) Trenton N.J.

15 SEP 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/1924

17

I HEREBY CERTIFY, That I attended deceased from 8/27, 1924, to 9/1, 1924, that I last saw her alive on 9/1, 1924, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic, Nephritis + Arterio Sclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy + study

(Signed) Clement R. Monroe, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trenton N.J.

DATE OF BURIAL 9/3/1924

20 UNDERTAKER Harry R Eckman

ADDRESS 832 Fremont Ave

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39882

CERTIFICATE OF DEATH.

D 39882

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3179 Abell Ave) (ST. 17 WARD)

2-FULL NAME John McGlynn

(a) RESIDENCE No. 3179 Abell Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McElroy

6 DATE OF BIRTH (month, day, and year) — — 1833

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
91	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McElroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant A. Seufert (Address) 3179 Abell Ave

15 Filed SEP 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1924, to Aug 30, 1924, that I last saw him alive on Aug 29, 1924, and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer L. Todd M. D.

8/30, 1924 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

DATE OF BURIAL 9/2 1924

UNDERTAKER P. J. Lahey & Sons

ADDRESS 131 S. Eutaw St

N. B.—WHITE PAPER, BLACK INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39883

Astarito

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39883

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 203 Balair Road ST., 47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tessa Astarito

(a) RESIDENCE NO. 203 Balair Road WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Astarito

6 DATE OF BIRTH (month, day, and year) 12/5/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Aversa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Trapani

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Trapani
(Address) 1200 Blk Madison St

15 Filed SEP 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Henry Morrison, M. D.
(Coroner)

Aug 31, 1924 (Address) 1232 R. Lab Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL 9/2 1924

20 UNDERTAKER George Ruth ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89884

CERTIFICATE OF DEATH.

127 D 89884

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Monument × 8 ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Maud Johnson

(a) RESIDENCE NO. Monument and 8 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Taylor Johnson

6 DATE OF BIRTH (month, day, and year) April 4 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Elijah Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary J. Johnson (Address) Monument & 8

15 SEP 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 30, 1924, that I last saw him alive on Aug 29, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

A. Pancreatitis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W. White Jr. M. D.

Sept 1 1924 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Sept 2 1924

20 UNDERTAKER H. J. Tuckwell & Son ADDRESS Balto

N. B.—WRITE PLAINLY, with ink. All questions should be answered. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89885

CERTIFICATE OF DEATH.

90 D 89885

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jessie H. Stocksdale

(a) Residence No. 2806 Pennsylvania ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Stocksdale

6-DATE OF BIRTH (month, day and year) 1862

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Carroll Co., Md.

PARENTS.

10-NAME OF FATHER, Josiah Stocksdale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Carroll Co., Md.

12-MAIDEN NAME OF MOTHER, Lucinda Armacost

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Carroll Co., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- SEP 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-31-24

17- I HEREBY CERTIFY, That I attended deceased from 5-27, 1924 to 8-31, 1924

that I last saw him alive on 8-30, 1924

and that death occurred, on the date stated above, at 12.45 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

and Myocarditis,

Mitral Insufficiency

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Draco, M. D.

8-31, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Sept 3 1924

20-UNDERTAKER. W. J. Tickner & Sons

ADDRESS North Ave

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 39886

~~D~~ 39886

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1609 Retreat St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....William L.Fredenburg,

(a) Residence No. 1609 Retreat St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cora L.Fredenburg.

6-DATE OF BIRTH (month, day and year) April 28,1872

7-AGE,	If LESS than 1 day,
52 yrs. 4 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Motorman

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....U.E.R.R.Co

9-BIRTHPLACE (city or town).....
(State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo.Fredenburg.

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER, Anna Mary Long.

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country) Baltimore Md.

14- (Informant) Mrs.Cora L.Fredenburg.
(Address) 1609 Retreat St.

15- ROBERT R. KRAUTER,
Title Burial Permit Clerk.
SEP 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEP 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Aug 31, 1924, that I last saw h[illegible] alive on Aug 31, 1924, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation
Mitral Regurgitation
Myocarditis

(Duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Joseph Sudler M. D.

, 19 (Address) 2348 Auburn Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL, London Park DATE OF BURIAL, SEP 3 1924, 19..

20-UNDERTAKER, Geo W Little ADDRESS 2700 Pennsylvania Ave

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89887

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH: Happy Hollow

City of BALTIMORE: (No. Brooklyn Md. St., 25 Ward) x90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Robertson

(a) Residence No. Brooklyn Md. St., ... Ward ..... Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mattie Robertson

6-DATE OF BIRTH (month, day and year): Sept 5—1871

7-AGE. 52 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): P. O. R.R.

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Mathew Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Caroline Walters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14-Informant: Mrs Thos H. Robertson

(Address): Happy Hollow Store

15-Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

SEP 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 30-24

17-I HEREBY CERTIFY, That I attended deceased from July 1st 24 19.. to Aug 30th 24 19..

that I last saw him alive on Aug 29th 24 19.. and that death occurred, on the date stated above, at 7 05 P

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Mitral Insufficiency

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Henry B. Holt M. D

by John (Address) 1103 Light

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Staunton Va — DATE OF BURIAL: Sept 1st 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E Nat.

Spec—12-23-21—E.B.R.S.—400 Bks. should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89388 — 188-001 — D 89388

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital St. 13 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther H. Brown

(Residence in Baltimore: No. 3104 Cedar Ave. St.) Yrs. 30 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 7 (Day), 1883 (Year)

7-AGE, 41 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bakeman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Penna. R.R.

9-BIRTHPLACE, (State or Country), Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Clementine Hyson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clyde M. Brown

(Address) 3104 Cedar Ave

15-

Filed SEP 2 - 1924 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 1 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said James Easton (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Both Crushed under wheels of train of B & O R.R. accident (while on duty)

(Duration) ....yrs, ...mos. 3 ...ds.

CONTRIBUTORY (Secondary) Gas Gangrene infection

(Duration) ....yrs. ....mos. 2 ...ds.

(Signed) James M. Easton M. D. (Coroner.)

Sept 1, 1924 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ....yrs. ....mos. 3 ...ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence 3104 Cedar Ave

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Sept 3, 1924

20-UNDERTAKER Horace H. Burgee — ADDRESS 363 Fallsway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89889

CERTIFICATE OF DEATH.

90 D 89889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes Sinclair

(a) RESIDENCE NO. 231 E 25th ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malcolm Sinclair

6 DATE OF BIRTH (month, day, and year) Feb 11-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
66	66	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leonard Kuhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Baer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant G. Marie Dornberg

(Address) 231 E. 25th St.

15 Filed SEP 2 - 1924 HUBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1924, to Aug 31, 1924, that I last saw h.. alive on Aug 31, 1924, and that death occurred, on the date stated above, at 12.20 P.m.

The CAUSE OF DEATH* was as follows:

[redacted]

Acute Cardiac Dilatation

(duration) 30 minutes yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene Leopold M. D.

. 19 (Address) 700 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 2 1924
20 UNDERTAKER	ADDRESS
H Sanders & Sons	110 Fleet St

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. Prolonged CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 39890

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 ✓

CERTIFICATE OF DEATH.

D 39890

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2641 Bernard St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Baker

(a) Residence No. 2641 Bernard St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 18 1923

7-AGE. ....yrs. 11 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Edward Shaffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary Baker

(Address) 2641 Bernard St

15- SEP 2 - 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 31-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1924 to Sept 1 1924 that I last saw h.. alive on Aug 31 1924 and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. P. Parry M. D.

, 19 (Address) 3101 Oakfield

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Cem — DATE OF BURIAL. Sept 2, 1924

20-UNDERTAKER. CHENOWETH & SON — ADDRESS

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89891

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2721 Aetkinson Ave (Ward) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack E Fendon

(a) Residence No. 2721 Aetkinson Ave (Ward) Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Nov 1923

7-AGE. yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Pa

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Mabel Fendon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa

14- (Informant) Jos Tappin

(Address) 2721 Aetkinson Ave

15-

16-UBERT R. KRAUTER, Registrar.

SEP 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 19 24, to Aug 31 19 24

that I last saw h alive on Aug 31 19 24

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

E Hamphrey

Lead Poisoning

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L A Reichardt M. D.

(Address) 112 W 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 2 1924

20-UNDERTAKER: CHENOWETH & SON, 3617 CHESTNUT AVE — ADDRESS

Should be carefully supplied. Age should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89892

CERTIFICATE OF DEATH.

129 D 89892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 W. Henrietta ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Janney.

(a) RESIDENCE NO. 426 W. Henrietta ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Janney.

6 DATE OF BIRTH (month, day, and year) Aug - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	41	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Veney

11 BIRTHPLACE OF FATHER (city or town) Richmond Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Susie Turner

13 BIRTHPLACE OF MOTHER (city or town) Richmond Co. (State or country) Virginia

14 Informant Rosie Seydnor

(Address) 426 W Henrietta St.

15 Filed ....., 19 .... ROBERT R. KRAUTER Registrar

SEP 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30 1924

17

I HEREBY CERTIFY, That I attended deceased from June, 1, 1923, to 8/30, 1924, that I last saw h alive on 8/30, 1924, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

6 Chronic Diffuse Nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Urine + Blood pr

(Signed) Wm Jouden M. D.

9/1. 1924 (Address) 1522 E Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharps Wks. Richmond Co. Va

DATE OF BURIAL Sept 3 1924

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hull St

N.B.—Information should be carefully supplied. AGE should be stated EXACTLY. Illegible or incomplete CERTIFICATES OF DEATH will not be accepted. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89893 ✓ D 89893

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 Smith St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Brown

(a) Residence No. 633 Smith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ ~~WIFE of~~ Hilt Brown

6-DATE OF BIRTH (month, day and year) June 3 1864

7-AGE, 25 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Junk Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer) O'H'S

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Nicholas Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mrs Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant) Alice A. Bailey

(Address) 633 Smith St

13- SEP 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30-1924

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to Aug 30, 1924, that I last saw him alive on Aug 30, 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY —
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Date

What test confirmed diagnosis? Clinical History

(Signed) Frank E. Watson, M. D.

Aug 31, 1924 (Address) 606 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL, Sept 2 1924

20-UNDERTAKER Helen A. Hollang ADDRESS 1631 Druid Hill Ave

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

D 89894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna Smith.....

(a) Residence No. 916 Perry St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington D.C

12-MAIDEN NAME OF MOTHER, Sarah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C

14-

(Informant) Thos Douglas

(Address) 932 W. Saratoga St

15-

SEP 2 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1924 to Aug. 30, 1924, that I last saw h.er alive on Aug 29, 1924 and that death occurred, on the date stated above, at 1 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the jejunum and of the stomach with metastasis to the liver

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Chronic Colitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Balt

Did an operation precede death? Yes Date of Aug 28/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clin phys Autopsy

(Signed) J. W. Bartelme M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Auburn Cemetery

DATE OF BURIAL, Sept 2, 1924

20-UNDERTAKER. John H. Owens

ADDRESS 538 Dolphin St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 89895 V

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89895

CERTIFICATE OF DEATH. STILL BIRTH NO. ~~14008~~

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 75 Mill Race Hilldale WARD) 28

REGISTERED NO. C 164-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby

(Residence in Baltimore: No. 75 Mill Race St.; Hilldale ...yrs.,...mos.,...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	X

6-DATE OF BIRTH, Sept 29, 1924 (Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Hilldale

PARENTS.

10-NAME OF FATHER, Harry Brown

11-BIRTHPLACE OF FATHER (State or Country), Arizona

12-MAIDEN NAME OF MOTHER, Hazel Lawson

13-BIRTHPLACE OF MOTHER (State or Country), U S A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- SEP 2 - 1924 ROBT. P. KRAUTER, Registrar.

Burial Permit Issued

1736

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ...191..., to ...191..., that I saw h...alive on ...191..., and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Baby 4 hrs Months

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) Theo Gerstenhaber M. D.

Sept 29, 1924 (Address) 1 Woodbourne Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

(Commissioner of Health.)

AUG 30 1924

WM. E. WOODALL

N. B.—Every item of information must be given, and every question answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39896

CERTIFICATE OF DEATH.

166-001

D 39896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St. 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Fisher

(a) RESIDENCE NO. 2924 Rockrose St. 4th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Fisher

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Fisher

(Address) 1439 E Baltimore St

15 Filed ..... 19 .....

ROBERT B. KRAUTER, Burial Permit Clerk Registrar

SEP 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to Sept 1, 1924

that I last saw him alive on Sept 1, 1924,

and that death occurred, on the date stated above, at 6:55 P m.

The CAUSE OF DEATH* was as follows:

Erythema Multiforme

(duration) — yrs. — mos 70 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Lorman Sherman, M. D.

9/1, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Sept 2 1924

20 UNDERTAKER Joseph Levin

ADDRESS 1439 Eastern

AGE should be stated EXACTLY. Physicians should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 89897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89897

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Margaret Weber

CITY OF BALTIMORE: (No. Arlington & Glenmore St. or Ave. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Weber

(a) RESIDENCE. NO. Arlington & Glenmore ST. Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos Weber

6 DATE OF BIRTH (month, day, and year) Sept 17 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Linderman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER M Rumple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Selma Weber

(Address) 612 N. Miller ave

15 Filed 19 ROBERT R. KRAUTER, Burial Permit Clerk

SEP 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-24

17 I HEREBY CERTIFY, That I attended deceased from 8-1-24 to 8-30-24, 19..., that I last saw h[illegible] alive on 8-30-24, 19..., and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jno L Rumple M.D.

9-1-24 (Address) 600 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakdawn Cemetery	Sept 3 1924
20 UNDERTAKER	ADDRESS
Johannah Canole	1004 Pulaski st

N. B.—WRITE PLAINLY. All questions should be answered. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89898 ✓ 89898

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 117 So-First ST., (Ward) 6 Fairhaven

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Ege

(a) RESIDENCE NO. 117 S. First ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ege

6 DATE OF BIRTH (month, day, and year) April 9th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr John Ege

(Address) 117 S First St

15 Filed SEP 2 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924 to Aug 31, 1924

that I last saw h[illegible] alive on Aug 30, 1924

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Sept 2, 1924 (Address) 1 E Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 2 1924

20 UNDERTAKER Peter Nicolaus — ADDRESS 2060 Eastern Av

AGE should be carefully supplied. Age should be stated EXACTLY. If [illegible] so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89899

CERTIFICATE OF DEATH.

REGISTERED NO. 1130

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Cushman ST., 15 WARD)

2-FULL NAME Wallis D. Jones

(a) RESIDENCE NO. 1420 Cherimon ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4th 1924

7 AGE: Years | Months 3 | Days 27 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Bentley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Jones 1420 Cherimon St

15 Filed SEP 2 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 29th 1924 to Aug 30th 1924

that I last saw him alive on Aug 30th 1924

and that death occurred, on the date stated above at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Toxic-enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Chemical

(Signed) H. Lee Ellis, M. D.

(Address) 1420 Cherimon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemtery	Sept 4 1924
20 UNDERTAKER	ADDRESS
Mrs Jas. H. Dennis per. J. E. Nelson	1303 Bressman St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Abbreviations may be used, but it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89900

CERTIFICATE OF DEATH.

90 D 89900

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Adams ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Roeder

(a) RESIDENCE NO. 9 Adams St. ST., WARD 9th.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Roeder

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Roeder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adam Roeder Father D

(Address)

15 SEP 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to Aug. 30, 1924, that I last saw him alive on Aug. 30, 1924, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Cardiac Failure

(duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) Chronic Nephritis, Br. Asthma, Chr. Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs.

(Signed) M E Cole M. D.

, 19 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 2 19

20 UNDERTAKER Harry A. Witzke

ADDRESS 1531 W. Lombard

AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Glover.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 ✓

CERTIFICATE OF DEATH.

D 39901

D 39901

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 762 W. Franklin St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia M. Glover.

(a) RESIDENCE NO. 762 W. Franklin St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Glover.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Neal

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Walter Glover
(Address) 762 W. Franklin St

15 Filed SEP 2 - 1924, 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

gastro-enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) 2802 Edmondson Ave.

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	9/2 1924

20 UNDERTAKER Jas. Jno. Kinnier ADDRESS 1620 E. Lead st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

39902

HEALTH DEPARTMENT—CITY OF BALTIMORE

39902

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 East 21st. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ellen Croswell

(a) RESIDENCE No. 20E. 21st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield Croswell

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Charles M. Croswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Clara B. Wampler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md.

14 Informant Mrs. Clara Croxton

(Address) 20 E. 21 St

15 Filed SEP 2 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1923 to Sept 1st 1924, that I last saw h[er] alive on Aug 31 1924, and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Diabetes

(duration) About 2 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. S. Sargent, M. D.

9/2 1924 (Address) 1117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md. DATE OF BURIAL Sept 3 1924

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS North

N. B.—WRITE PLAINLY; PENCIL not to be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89903

74 001 V

D 89903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N Bond ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella B. Bowers Diegelman

(a) RESIDENCE NO. 921 N Bond St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1869

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Henry McMillan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Susan Grubb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Joseph N. Diegelman 921 N Bond St

15 Filed SEP 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1924, to Sept 1st, 1924.

that I last saw her alive on Sept 1st, 1924.

and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (test) confirmed diagnosis?

(Signed) Louis Faust, M. D.

Sept 1, 1924 (Address) 501 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Sept. 4 1924

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager St

A CERTIFICATE OF DEATH should be carefully supplied. AGE should be filled IN ALL CASES. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89904

CERTIFICATE OF DEATH.

Registered No. 47

1-PLACE OF DEATH

City of BALTIMORE: (No. 1818 Division St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Nicholson

(a) Residence No. 1818 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col

5-~~Single~~ Married, Widowed, or Divorced. (Write the word.) Wid

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Jeremiah Nicholson

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) Ott

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hartford Ct

PARENTS.

10-NAME OF FATHER, Thos. Webster

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hannah Perry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

11- (Informant) Jeremiah Nicholson

(Address) 1818 Division St

15- Filed SEP 2 - 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 31 1924

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to Aug 31, 1924, that I last saw her alive on Aug 30, 1924, and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Frank E. Hilbert M. D.

, 19 (Address) 1716 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Cem DATE OF BURIAL, 9/2/24, 19

20-UNDERTAKER, Lauder O'Grady ADDRESS 578 N Bradd

Should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. In plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 89905

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pembleton

(a) Residence No. 2204 Ettinge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Pembleton Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- SEP 2 - 1924 ROBERT A. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-30-24

17- I HEREBY CERTIFY, That I attended deceased from 3-20-, 19 24 to 8-30, 19 24

that I last saw h.. alive on 8-30, 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis (Degenerative)

Myocardial Insufficiency

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Claude A. Drace, M. D.

8-31, 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem DATE OF BURIAL, Sept 3, 1924

20-UNDERTAKER, Wm H Crase Sons ADDRESS 400 Mosher

Instructions be carefully supplied. Exact statement of OCCUPATION is very important. Data should be properly classified. Exact statement of OCCUPATION is very important. Data should be properly classified in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39906

CERTIFICATE OF DEATH.

31 B

D 39906

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Brady

(a) Residence No. 216 Slammers Alley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE.	If LESS than 1 day.
57 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Brady

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept.1,1924

17- I HEREBY CERTIFY, That I attended deceased from March 17 1924 to Sept. 1 1924

that I last saw him alive on Sept. 1 1924

and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Arteriosclerosis

Chronic nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) J. D. Wilkins, M. D.

9-1- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Harford Rd	Sept 1 1924
20-UNDERTAKER.	ADDRESS.
Wm Cook	502 E Northern

N. B.—Write plainly. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be certified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89907

D 89907

CERTIFICATE OF DEATH.

REGISTERED NO. 459

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Dept Balt General Hosp St. [illegible] WARD)

2-FULL NAME Wm Thomas Dougherty

(a) RESIDENCE No. 1108 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Dougherty

6 DATE OF BIRTH (month, day, and year) July 4, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Making Brooms.

(c) Name of employer Mr John Ripple. Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. Dougherty (Address) 1108 N. Fremont Ave

Filed SEP 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 26. 1924. to Aug 31. 1924.

that I last saw him alive on Aug 31. 1924

and that death occurred, on the date stated above, at 10.40 m.

The CAUSE OF DEATH* was as follows:

(1) Carcinoma of gut.

(2) with intestinal obstruction

no known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) intestinal obstruction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) W. G. Caspary, M. D.

(Address) 2303 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Sept 2nd 1924

20 UNDERTAKER Josiah Syper ADDRESS 1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should write all information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89903

HEALTH DEPARTMENT—CITY OF BALTIMORE

X74-001

D 89908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 9 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Durfour

(a) Residence No. Pikesville Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 65 years Unknown mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Marshal Stansbury

(Address) Pikesville, Md.

15- SEP 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 29 1924 to Aug. 31 1924 that I last saw h im alive on Aug. 31 1924 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Myocard Insufficiency

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Irvin Greenblatt M. D.

8/31, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Ashury M E Cemetery — DATE OF BURIAL, Sept 2 1924

20-UNDERTAKER, Reisterstown — ADDRESS

J. F. Ebaugh Reisterstown Md

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89909

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 89909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Clarkson ST., 73 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Reip

(a) RESIDENCE. NO. 1523 Clarkson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph S. Reip

6 DATE OF BIRTH (month, day, and year) April 26, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Ransom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Joseph S Reip 1523 Clarkson

15 Filed SEP 2 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Aug 30, 1924, that I last saw h.. alive on Aug 29, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. L. Campbell, M. D.

Aug 31, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 9/1/ 1924

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Eutaw

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS SHOULD be careful to see that the information should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89910 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89910

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (Bay View Hospital St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] Edwards

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1856

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Samuel Edwards

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Louisa (unknown)

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) Hospital Records

(Address) Bay View Hospital Dodo

15-Filed SEP 2 1924 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-31-24

17- I HEREBY CERTIFY, That I attended deceased from 8-21 19 24 to 8-31 19 24, that I last saw h[redacted] alive on 8-31 19 24 and that death occurred, on the date stated above, at [redacted] m.

The CAUSE OF DEATH* was as follows:

Varicose ulcers of right leg lower 1/3
Beginning ulceration 2 left lower 1/3 leg.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Internal Bronchs Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) H. P. Kemper M. D.

(Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cemetery DATE OF BURIAL. Sept 2. 1924

20-UNDERTAKER. Edward J. Fanning & Son ADDRESS Lafayette & Washington

Should be carefully supplied. Exact statement of OCCUPATION is very important. If deceased was classified, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89911

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonia Lewandowski

(a) RESIDENCE NO. 3-098 S. Regester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Wid

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work worked out.
(b) General nature of industry, business, or establishment in which employed (or employer) any work.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Plechowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Zygmunt Lewandowski

(Address) 3098 Register

15 Filed SEP 2 - 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction 3 days

Probable injury to bowel caused by enema taken from a boy

CONTRIBUTORY (Secondary) 3 days.

(duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.

(Coroner.)

Sept 1, 192 4 (Address) 1039 Fawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 3 192 4

20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations not to be used. Indefinite terms, as "Debility," "Old Age," "Infirmity," "Paralysis," "Convulsions," "Cancer," "Tumor," "Abscess," "Consumption," "Dropsy," "Fever," "Hemorrhage," "Inflammation," "Ulceration," "Gangrene," "Blood Poisoning," "Heart Disease," "Kidney Disease," "Liver Disease," "Lung Disease," "Stomach Disease," "Bowel Disease," "Brain Disease," "Spinal Disease," "Nervous Disease," "Skin Disease," "Bone Disease," "Joint Disease," "Muscle Disease," "Tendon Disease," "Ligament Disease," "Cartilage Disease," "Synovial Disease," "Bursa Disease," "Fascia Disease," "Aponeurosis Disease," "Tendon Sheath Disease," "Ligament Sheath Disease," "Cartilage Sheath Disease," "Synovial Sheath Disease," "Bursa Sheath Disease," "Fascia Sheath Disease," "Aponeurosis Sheath

Spec.—1-10-21—M&T—1500 Bks.

D 89912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 19 WARD)

REGISTERED NO. 160

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Baby) Lorain Hobbs

(a) RESIDENCE No. 403 South Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) July 26. 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Leo Hobbs

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Irene Ramsey

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Leo Hobbs
(Address)

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Aug 31, 1924, that I last saw h[illegible] alive on Aug 31, 1924, and that death occurred, on the date stated above, at 10⁰⁰ Pm.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Donald Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: SEP 2 1924 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

SEP 2 - 1924

1755

WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. If infant, state whether child of white or colored parent. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 89913 .

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89913

CERTIFICATE OF DEATH.

6 16

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 Orleans St. ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unnamed babe McDaniel

(Residence in Baltimore: No. 2040 Orleans St. St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	~~single~~

6-DATE OF BIRTH, Sept I 1924, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
XX yrs. XX mos. XXIX. ds.	10 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. McDaniel

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lula Davis

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Wm. McDaniel (Informant)
(Address) 2040 Orleans St.

15- JOHNS
Filed SEP 2 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept I (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept I 24 Sept I 24 im ..... 191..., to ..... 191...,
that I saw h..... alive on Sept I 1924 191...,
and that death occurred, on the date stated above, at 1.02A m.
The CAUSE OF DEATH* was as follows:

Asphyxia
about 10 Minutes (Duration) ...yrs. ...mos. ...ds.
Breech Presentation
CONTRIBUTORY (Secondary)
..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Ralph L Hurst M. D.
Sept I, 191.. (Address) 726 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
HOPKINS HOSPITAL	SEP 2 1924

20-UNDERTAKER Commissioner Health. ADDRESS

Per Wm F WOODALL

N. B.—Every item of information should be given as accurately as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89914

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ~~620 Clinton Ave~~ ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Scott.

(a) RESIDENCE NO. 620 Clinton Ave City, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Scott

6 DATE OF BIRTH (month, day, and year): July 25-

7 AGE: Years 59 Months 1 Days 7

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. A. H. Schaffer

(Address) 632 E. Eastern Ave

15 Robert P. Harrison, 19 Registrar

SEP 2 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1924, to Sept 1, 1924,

that I last saw h.. alive on Sept 1, 1924,

and that death occurred, on the date stated above, at 10.45 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Myocarditis

Aortic Aneurism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture Aortic Aneurism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No Special Test.

(Signed) R. G. Rice, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept 3 1924

UNDERTAKER: George L. Schwab — ADDRESS: 2101 Fruit A.

B.—WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1548 N. Fulton ave St. 15 Ward)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number.)

2-FULL NAME Jesse Lee McCrea

(a) Residence No. 1548 N. Fulton ave St., ... Ward, ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McCrea

6-DATE OF BIRTH (month, day and year) Sept. 17 1858

7-AGE. 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Plumber 54

(b) General nature of industry, business, or establishment in which employed (or employer)..... 05

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James McCrea

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Eliza Constable

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Mary McCrea

(Address) 1548 N. Fulton ave

15- Filed ..... 19 24 Robert P. Harrison, Registrar.

Burial Permit Clerk.

P2 - 1524

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 19 24 to Aug 31 19 24 that I last saw h.. alive on Aug 31 19 24 and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis R

Angina Pectoris

(Duration) 2 yrs. mos. 3 ds

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of None

Was there an autopsy? None

What test confirmed diagnosis?.....

(Signed) Chas A. Fetterhoff M. D.

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge	Sept 1 1924
UNDERTAKER	ADDRESS
John C. Mitchell	2011 W Lanvale

Cor.—1-12-23—M&T—100 Bks.

D 89916

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 89916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Wicomico ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth H Munch.

(a) RESIDENCE NO 1925 Wicomico ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis M Munch

6 DATE OF BIRTH (month, day, and year) Nov 6th 1849

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Henry Earl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma L Mitchell
(Address) 1121 Scott St

15 Filed SEP 2 - 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) at once yrs. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ds. ds.

(Signed) Thos W Morton M. D.
(Coroner.)

Sept 1st 1924 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side of certificate.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 3 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH to be plainly written, so that any Physician can understand it. Use no abbreviations or contractions. Statements of "Heart Disease," "Pneumonia," "Cancer," "Consumption," "Paralysis," "Convulsions," "Old Age," "Dropsy," "Cholera Infantum," "Marasmus," "Debility," "Childbirth," "Abscess," "Tumor," "Fever," "Inflammation," "Hemorrhage," "Ulceration," "Gangrene," "Blood Poisoning," "Meningitis," "Locomotor Ataxia," "Uremia," "Septicemia," "Pyemia," "Peritonitis," "Tuberculosis," "Tuberculosis of Lungs," "Tuberculosis of Brain," "Tuberculosis of Bowels," "Tuberculosis of Kidneys," "Tuberculosis of Spine," "Tuberculosis of Joints," "Tuberculosis of Glands," "Tuberculosis of Skin," "Tuberculosis of Bones," "Tuberculosis of Liver," "Tuberculosis of Spleen," "Tuberculosis of Stomach," "Tuberculosis of Intestines," "Tuberculosis of Pancreas," "Tuberculosis of Kidneys," "Tuberculosis of Bladder," "Tuberculosis of Prostate," "Tuberculosis of Testicles," "Tuberculosis of Ovaries," "Tuberculosis of Uterus," "Tuberculosis of Vagina," "Tuberculosis of Vulva," "Tuberculosis of Penis," "Tuberculosis of Scrotum," "Tuberculosis of Anus," "Tuberculosis of Rectum," "Tuberculosis of Perineum," "Tuberculosis of Groin," "Tuberculosis of Thigh," "Tuberculosis of Leg," "Tuberculosis of Foot," "Tuberculosis of Toe," "Tuberculosis of Arm," "Tuberculosis of Hand," "Tuberculosis of Finger," "Tuberculosis of Shoulder," "Tuberculosis of Neck," "Tuberculosis of Head," "Tuberculosis of Face," "Tuberculosis of Eye," "Tuberculosis of Ear," "Tuberculosis of Nose," "Tuberculosis of Mouth," "Tuberculosis of Throat," "Tuberculosis of Lungs," "Tuberculosis of Brain," "Tuberculosis of Bowels," "Tuberculosis of Kidneys," "Tuberculosis of Spine," "Tuberculosis of Joints," "Tuberculosis of Glands," "Tuberculosis of Skin," "Tuberculosis of Bones," "Tuberculosis of Liver," "Tuberculosis of Spleen," "Tuberculosis of Stomach," "Tuberculosis of Intestines," "Tuberculosis of Pancreas," "Tuberculosis of Kidneys," "Tuberculosis of Bladder," "Tuberculosis of Prostate," "Tuberculosis of Testicles," "Tuberculosis of Ovaries," "Tuberculosis of Uterus," "Tuberculosis of Vagina," "Tuberculosis of Vulva," "Tuberculosis of Penis," "Tuberculosis of Scrotum," "Tuberculosis of Anus," "Tuberculosis of Rectum," "Tuberculosis of Perineum," "Tuberculosis of Groin," "Tuberculosis of Thigh," "Tuberculosis of Leg," "Tuberculosis of Foot," "Tuberculosis of Toe," "Tuberculosis of Arm," "Tuberculosis of Hand," "Tuberculosis of Finger," "Tuberculosis of Shoulder," "Tuberculosis of Neck," "Tuberculosis of Head," "Tuberculosis of Face," "Tuberculosis of Eye," "Tuberculosis of Ear," "Tuberculosis of Nose," "Tuberculosis of Mouth," "Tuberculosis of Throat," are not sufficient. Name the disease causing death, or in deaths from violent causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side of certificate.)

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89917

CERTIFICATE OF DEATH Mt Washington 90 D 89917

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Ridge Road Hill Top (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Sparks

(a) RESIDENCE No. Ridge Rd Mt Wash ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. 3 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sparks

6 DATE OF BIRTH (month, day, and year) July 16 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Kratz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kratz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Sparks

(Address) Ridge Road Hill Top Park.

SEP 2 1924 Filed 19 Robert P. [illegible]

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1. 1924

17

I HEREBY CERTIFY, That I attended deceased from continously for 10 years, to 19

that I last saw her alive on Sept 1 , 1924

and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 10 yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr C R Decker M. D.

19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 4 1924
20 UNDERTAKER	ADDRESS
Mr & Mrs. J. W. Teufel & Son	1801 N. Fayette

AGE should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 89918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 89918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4802 Hamilton Ave ST., Howard Park WARD)

2-FULL NAME Henry C. Johnson

(a) RESIDENCE No. 4802 Hamilton Ave ST., Howard Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov. 2. 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
28	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 1034

(c) Name of employer Rudolph Johnson

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rudolph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Klemstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rudolph Johnson

(Address) 4802 Hamilton Ave Howard Park

15 Filed SEP 2 1924, 19 Robert T. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1. 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Sept 1st, 1924, that I last saw h—alive on Sept 1st, 1924, and that death occurred, on the date stated above, at 9. A. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Alcoholic Inunitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Chesnut M. D.

1924 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept. 4. 1924

20 UNDERTAKER Chas. H. Sumwalt Jr. ADDRESS 801 W. Fayette St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 89919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D 89919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Dr. Hamburg ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret R. Gray

(a) RESIDENCE NO. 1139 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zachariah T. Gray Sr.

6 DATE OF BIRTH (month, day, and year) July 22. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas Henthorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary J. Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Zachariah T. Gray (Address) 1139 W. Hamburg St.

15 Filed ..... Robert P. Harrison, Registrar

SEP 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 24. 19.. to Aug 31. 24

that I last saw h.. alive on Aug 31. 19 24

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Schwerdt M.D.

19 (Address) 11 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Sept 3. 1924

20 UNDERTAKER Mr. & Mrs. J. W. Tenfel & Son ADDRESS 801 W. Fayette

P. S. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1319 Ensor St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edna J. Smith.

(a) Residence No..... 1319 Ensor St. St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 9, 1882.

7-AGE. 42. yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At home.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Kentucky.

PARENTS.

10-NAME OF FATHER, Dont know.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kentucky.

12-MAIDEN NAME OF MOTHER, Mary Miller.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Kentucky.

14-

(Informant)... Adam Smith.

(Address)..... 1319 Ensor St.

15-

Filed 192 Robert P. Harrison, Registrar.

P2 -1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 30, 19 24, to Sept. 1, 1924, that I last saw h. er alive on Aug. 31, 19 24, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration)..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) chronic nephritis.

.....(Duration)..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Howard Evans, M. D.

Sept. 1 19 24 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Louden Pk bem

DATE OF BURIAL, Sept 3 1924

20-UNDERTAKER. A. Howard Evans

ADDRESS 38 E. Fort Ave

Should be carefully filled in, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89921

CERTIFICATE OF DEATH.

24 101 501

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1807 Westphal St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bertha M. Tucker.

(a) Residence No..... 1807 Westphal St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6-DATE OF BIRTH (month, day and year) June, 19, 1924

7-AGE. .....yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Tucker.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Bertha Zober.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant)..... Bertha Tucker Sr. (Address)..... 1807 Westphal St.

15- Filed 19? Robert P. Harrison, Registrar.

SEP 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1 24.

17- I HEREBY CERTIFY, That I attended deceased from May 31 19.. to Sept 1 19.., that I last saw h.. alive on Sept 1 19.., and that death occurred, on the date stated above, at 11 35 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

Jaundice (Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary)

.....(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of —

Was there an autopsy? ?

What test confirmed diagnosis? Autopsy

(Signed) Henry Bilicki, M. D.

Sept 1 24 (Address) 1203 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery. DATE OF BURIAL. Sept 3 1924

20-UNDERTAKER. A. Edward Evans. ADDRESS 38 E. Fort Ave

Should be carefully supplied. Fill in all blanks. Exact statement of OCCUPATION is necessary. Illegible or illegibly written words cannot be classified. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 821 Light St., 24 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Burnup

(a) Residence No. 821 Light St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 19 1913

7-AGE. 11 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Alfred S Burnup

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Bertha Cannon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14-(Informant) Mr Alfred S Burnup

(Address) 821 Light St

15-Filed P 2 - 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2 1924

17-I HEREBY CERTIFY, That I attended deceased from Aug 31 1924 to Sept 2 1924

that I last saw him alive on Sept 1 1924

and that death occurred, on the date stated above, at 12:30 PM

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. Harrison, M. D.

(Address) 18 Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL. Sept 3 1924

20-UNDERTAKER. John F Denny

ADDRESS. 715 Light St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 W. Barre St., 21 Ward)

Registered No. 1350

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theodore Tanchico

(a) Residence No. 1029 W Barre St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 24/23

7-AGE, 1 yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Sisenander Tanchico

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Philippine Island

12-MAIDEN NAME OF MOTHER Gertrude Koenig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Brooklyn Maryland

14-(Informant) Mrs Gertrude Tanchico

(Address) 1029 W Barre st

15-FILED SEP 2 1924

Robert P. Harrison, 192.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1 1924

I HEREBY CERTIFY, That I attended deceased from July 28, 1924 to Sept 1, 1924 that I last saw h[illegible] alive on Aug 31, 1924 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) 1 yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Diarrhoea

(Duration) 1 yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 1340 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill — DATE OF BURIAL, Sept 3, 1924

20-UNDERTAKER. John F Denny — ADDRESS 715 Lexington St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89924

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1700 Canewell St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Waldschmidt

(a) Residence No. 1700 Gaswell St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) March 28-1908

7-AGE, 16 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Louis Waldschmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Agata Ruuce

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Louis Waldschmidt

(Address) 1700 Canewell St

15- Filed ..... 19? Robert P. Harrison, Registrar.

P 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 31-1924

17- I HEREBY CERTIFY, That I attended deceased from April, 19 24, to Aug 31, 19 24, that I last saw him alive on Aug 31, 19 24, and that death occurred, on the date stated above, at 11.30 m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kinney, M. D.

9/1, 19 24 (Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Pikesville Cemetery	Sept 3, 24
20-UNDERTAKER, Robt Sinnes Son	ADDRESS W. Fayette

Should be carefully supplied. Age always required. In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89925

CERTIFICATE OF DEATH.

59-002

159 D 89925

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 318 S. Clinton St. St., N Ward)

2-FULL NAME..... John George Miller Jr.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 318 S. Clinton St St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 20-1924

7-AGE. ..... yrs. ..... mos. 12 ds.

If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John G. Miller Jr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Rene Rosenbaum.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) John G. Miller

(Address) 318 S. Clinton St.

15- Filed ..... Robert P. Harrison, Registrar.

P2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 1-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1924 to Sept 1 1924

that I last saw him alive on Sept 1 1924

and that death occurred, on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows:

Open Paranoid Psychosis

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tillow M. D.

9/2 1924 (Address) 310 S. Highlandtown

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cem. DATE OF BURIAL, Sept 5, 1924

20-UNDERTAKER, Lilly & Zirkin ADDRESS 403 S. Broadway

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39926

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Baker St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dena Zarden

(a) RESIDENCE No. 2212 Baker St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Zarden

6 DATE OF BIRTH (month, day, and year) about 1844 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER ? Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant David E. Hamburger
(Address) 2212 Baker St.

15 Filed SEP 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Sept. 2, 1924 (Address) 2 E Redwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebrew Russdale DATE OF BURIAL Sept 2 1924

20 UNDERTAKER Earl Levin ADDRESS 1492 E. Biddle

That it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.E.R.S.—400 Eks.

D 89927 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89927

CERTIFICATE OF DEATH. X117

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. St. Joseph's Hospital 9 St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary J. Burton

(a) Residence No. Joppa Road & Ferguson Lane Carney St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Burton

6-DATE OF BIRTH (month, day and year) Dec. 10th 1861

7-AGE. 62 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Co. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Asa. Kirkandall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Hannah Parlett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

14- (Informant) Benjamin Burton

(Address) Fullerton Md.

15- Filed 9-1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 1924 to Sept. 1st 1924 that I last saw her alive on Sept 1st 1924 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH was as follows:

Appendiceal Abscess following Acute appendicitis

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertonia and Myocarditis Senile M.D.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 8/25/24

Was there an autopsy? No What test confirmed diagnosis? Clinical and Operative

(Signed) A. C. Chambers, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept. 4, 1924
20-UNDERTAKER	ADDRESS
Fred'k Lancaster & Sons	Fullerton

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 89928

CERTIFICATE OF DEATH

31 D 89928

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 728 N Chester St. WARD) 1

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jacob Bumba

(Residence in Baltimore: No. 728 N Chester St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March (Month) 1 (Day) ..... (Year)

7 AGE: 61 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Jacob Bumba

11 BIRTHPLACE OF FATHER (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Anna Kurto

13 BIRTHPLACE OF MOTHER (State or country): Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Bumba

(Address) 728 N Chester St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

P2 - 1924

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September 2nd, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th, 1924, to August 31st, 1924, that I saw h[illegible] alive on August 31st, 1924, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(Duration) final 1 yrs. 2 mos. 17 ds.

Contributory (SECONDARY) Asthenia

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) William G. Odeton M. D.

Sept 2nd, 1924 (Address) 2919 Huntington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Oakhill — DATE OF BURIAL: Sept 4, 1924

20 UNDERTAKER: Black Brothers — ADDRESS: 1906 Eutaw

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89929

CERTIFICATE OF DEATH.

31 D 89929

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallace D. Stevens.

(a) RESIDENCE NO. 413 Belvidere Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Roberta Stevens.

6 DATE OF BIRTH (month, day, and year) May 21, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Fuller Stevens.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine.

12 MAIDEN NAME OF MOTHER Elizabeth Gannt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant David Stevens. (son)
(Address) 418 Belvidere Ave.

15 Date SEP 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Feb. 1, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Central Station. Aug. 27, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Pk Cem	Sept 3 1924
20 UNDERTAKER	ADDRESS
A. Howard Evans	38 E. Fort Ave

BEFORE SHOULD BE CERTAIN that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39930

CERTIFICATE OF DEATH.

129 D 39930

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 2228 Eastern Ave. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jurkowski

(a) RESIDENCE. No 864 S. Grove ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) 12
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Jurkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Victoria Sajdak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Jurkowski
(Address) 2228 Eastern Ave.

Filed SEP 3 - 1924 ROBERT R. KRAUTER, Clerk.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924, to Sept. 1, 1924, that I last saw him alive on Sept. 1, 1924, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronstein M. D.

9-1-. 1924 (Address) 3037 Odonnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	9-4 1924

20 UNDERTAKER F. W. Ozazewski ADDRESS 1930 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89931

CERTIFICATE OF DEATH.

129 D 89931

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 E. Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Purcell

(a) RESIDENCE. NO. 2623 E Oliver ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Purcell

6 DATE OF BIRTH (month, day, and year) Apr. 11, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	4	20	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Danl Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elz. Coughlan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie Purcell (Address) 2623 E. Oliver

15 SEP 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-26, 19 24, to 9-1, 19 24, that I last saw her alive on 9-1, 19 24, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Dana Fuller, M. D.

, 19 (Address) 1500 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Sep. 3, 19[illegible]

20 UNDERTAKER: Margaret D. Flynn ADDRESS: 1[illegible] Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. Fractions of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89932

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3730 E. Lombard St. St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Robert Marcellino

(a) Residence No. 3730 E. Lombard St. St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 10-1923

7-AGE, ...yrs. 8 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Tony Marcellino

11-BIRTHPLACE OF FATHER (city or town) Italy
(State or Country),

12-MAIDEN NAME OF MOTHER, Sarah Weir

13-BIRTHPLACE OF MOTHER (city or town) Balto.
(State or Country), Md.

14- (Informant) Sarah Marcellino.

(Address) 3730 E. Lombard St.

SEP 3 - 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from 8-29-1924 to Sept 2 1924 that I last saw he alive on Sept 1 - 1924 and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Enteritis Gastro Enteritis

.....(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) None

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) H. H. Hartman M. D.

(Address) 929 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Line. DATE OF BURIAL, Sept 3 1924

20-UNDERTAKER, Lilly & Zacher ADDRESS 403 S. Wolfe St.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 89933

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 89933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 W 38th St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence L. Bossom

(a) Residence No. 2208 Eagle St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 9 1922

7-AGE, 1 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Amos Bossom

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Priscilla Isaacs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Amos Bossom

(Address) 2208 Eagle St

SEP 3 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 19 24 to Sept. 2 19 24,

that I last saw him alive on Sept. 2 19 24

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Dehydration & Enteritis

(Duration) yrs. 2 mos. 10 ds. (history)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred B Smith M. D

, 19 (Address) 11 Eldebrook St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Hampden	Sept 3 19 24
20-UNDERTAKER.	ADDRESS
CHENOWETH & SON,	307 CHARLES AVE.

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89934

CERTIFICATE OF DEATH.

90 D 89934

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1231 Jefferson St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Moore

(a) Residence No. 1231 Jefferson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Dow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 72 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14- (Informant) Mathew Moore

(Address) 1231 Jefferson St

Filed SEP 3 - 1924 19.. ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Sept 1, 1924

that I last saw h.. alive on Aug 31 1924

and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Fisher M. D.

9-1, 1924 (Address) 1612 E monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
National Cemetery	9-3-, 1924
20-UNDERTAKER.	**ADDRESS**
Mrs Isaac L. Bailey	1423 Jefferson St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital Ward) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie White

(a) Residence No. 841 China st. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1895

7-AGE.	If LESS than 1 day,
29 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Alexander White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Charlotte Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 7 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4 1924 to Sept. 1 1924

that I last saw h. alive on Sept. 1 1924

and that death occurred, on the date stated above, at 7.55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. S. White M. D.

9-1- 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	Sept 3, 1924

20-UNDERTAKER.	ADDRESS
H. L. Brown & Son	W. Monument St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important

Spec—12-23-21—E.B.R.S.—400 Bks.

Catonsville
1701 N Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

89936

154-002

89936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3016 Tyndale St., Apt 2a Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME London K Evans

(a) Residence No. 3016 Tyndale St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 30 24

7-AGE, ...yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Morgan Evans

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Anna Green

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) Anna Evans

(Address) 3016 Tyndale St

15- Filed SEP 2 1924 ROBERT R. KRAUTH Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 30, 1924, to Sept 2, 1924,

that I last saw him alive on Sept 1, 1924

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart & Cyanosis

(Duration) ....yrs. ....mos. 6d ds.

CONTRIBUTORY (Secondary) Congenital Heart

(Duration) ....yrs. 4y mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D C Cannon M. D

9-2, 1924 (Address) 1701 N Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL, Sept 3, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E N Ave

SEP 2 1924

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89937

CERTIFICATE OF DEATH.

129 D 89937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824. Aisquith. ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie C. Chaney

(a) RESIDENCE NO. 1824. Aisquith. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clifton. Chaney

6 DATE OF BIRTH (month, day, and year): Oct. 30/875.

7 AGE — Years: 48. Months: 10. Days: ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael Tighe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Margaret Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Clifton Chaney
(Address): 1824 Aisquith St

15 Filed SEP 3 - 1924, 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Sept 1st, 1924, that I last saw h[illegible] alive on Aug 31, 1924 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Infantile Chronic,

(duration) ..... yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary): Chronic

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gunsolus, M. D.

9/4. 1924 (Address) 517 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral.	Sept 5 1924
20 UNDERTAKER	ADDRESS
Wm Crook.	5026 E. Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' and state mation should be carefully supplied. OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Moran) (Moran)

D 89938 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1208 Bayard St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Moran

(a) Residence No. 1208 Bayard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 9 - 1916

7-AGE, yrs. 8 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos P. Moran

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Jennett Kopp

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs Jos P. Moran

(Address) 1208 Bayard St

15- Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 29- 1924 to Sept 1- 1924

that I last saw h.. alive on Sept 1 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis Indigestion & Dysentery

(Duration) yrs. mos. 14 ds

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ethel Carlin M. D.

9/2, 1924 (Address) 2105 W Balto St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Sept 3 - 1924

20-UNDERTAKER: Joseph Cowen Son — ADDRESS: 901 Baltimore St

Joseph F. Cowen

should be carefully supplied. Age should be stated EXACTLY, if under 1 year, in days; if under 1 day, in hours or minutes. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Name of Disease should be stated. See instructions on back of certificates.

Cor.—t-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89939

CERTIFICATE OF DEATH.

1924 D 89939

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 829 Bevan St. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Powell. (C)

(a) RESIDENCE NO. 105 W. York St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ---mos.--- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a if married, widowed, or divorced, HUSBAND of (XXXXXXXXXX) Carrie Powell. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia.

PARENTS

10 NAME OF FATHER George H. Powell. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia.

12 MAIDEN NAME OF MOTHER Matilda ----(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia.

14 Informant Carrie Powell. (C) wife.
(Address) 105 W. York St.

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body badly decayed.
Autopsy disclosed nothing.
History: Overdose of Cocaine.
Homicide. (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) ..... (duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Sept. 1, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 3 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 N Saratoga ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fizzie Mollman.

(a) RESIDENCE NO. 1914 N. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Aug 27. 1858.

7 AGE — Years: 66. Months: Days: 6. If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. D Mollman

(Address): 1914 N Saratoga St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Sept 2, 1924,

that I last saw her alive on Sept 2, 1924,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -

(duration) yrs. mos. 8. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E. Travers M. D.

, 19 (Address) 500 Holland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetary

DATE OF BURIAL: Sept 4 1924

20 UNDERTAKER: Geo Limlacher Son

ADDRESS 647 W Lisbon St.

FEB 3 - 1924

NOTE—WRITE PLAINLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should mation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89941

CERTIFICATE OF DEATH.

161-60 2

D 89941

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St Agnes Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Phelps

(a) Residence No. 2548 McHenry St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 31/24

7-AGE. ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). St. Agnes Hospital

PARENTS.

10-NAME OF FATHER. Joshua W. Phelps

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Marie West

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Joshua Phillips

(Address) 2548 McHenry St.

15- Filed SEP 3 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 31, 1924 to Sept 2, 1924

that I last saw h[illegible] alive on Sept 2, 1924

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions + Coma

1 hour

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Dark brown probably cerebral hemorrhage

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? visual tests

(Signed) H. E. Krantz, M. D

Sept 2, 1924 (Address) 1002 N. Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. Sept. 3rd, 1924

20-UNDERTAKER. Geo. Lindsch + Son. ADDRESS 647 W. Pratt St.

should be carefully supplied. AGE should be stated EXACTLY. Information ... See ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

D 89942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002

D 89942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15 WARD)

2-FULL NAME Benjamin B Long

(a) RESIDENCE NO. 402 Hawthorne ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 11 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 078

(b) General nature of industry, business, or establishment in which employed (or employer) Agent U.R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas W Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Booze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Record

(Address)

15 Filed SEP 3 1924, 19.... R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2/24

17

I HEREBY CERTIFY, That I attended deceased from 8/21/24, 19.... to 9/2/24, 19....

that I last saw h alive on 9/2/24, 19....

and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 5 1924
20 UNDERTAKER	ADDRESS 553 L
Geo J Smith	Holliday

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should be careful to state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89943

CERTIFICATE OF DEATH.

197 D 89943

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Atlantic Ocean,

CITY OF BALTIMORE: (No. 60 miles off Savannah, Ga. WARD) 17

2-FULL NAME James Waters. (C)

(a) RESIDENCE No. 507 W. Preston St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married ~~Single~~.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clutsom

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter, 0-10
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Gloucester.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Waters. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Katie Young. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant J. Henry Waters. (C) brother.
(Address) 849 N. Eutaw St.

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Pistol shot wound in the chest.
Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Rennhardt, M. D.
(Coroner)
Sep. 2, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 9/3 1924

20 UNDERTAKER Daniel Rensley ADDRESS 1228

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89944 D 89944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Johns 2d ST. 14 WARD 101-001)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Coy

(a) RESIDENCE NO. 1716 Johns st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cornelia Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant M. C. Keating

(Address) 516 Tyler st

15 Filed SEP 3 - 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Augt 28, 1924, to Sept 1, 1924

that I last saw her alive on Sept 1, 1924

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H K Gorsel M. D.

9-3, 1924 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 4 1924
20 UNDERTAKER	ADDRESS
W M Routson	2238 W North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89945

CERTIFICATE OF DEATH.

129 D 89945

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Tillman ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt Sommerville

(a) RESIDENCE NO. 1530 Tillman ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Roberta Sommerville

6 DATE OF BIRTH (month, day, and year) Jan 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Unknown Balto Md

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Sommerville

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Md.

12 MAIDEN NAME OF MOTHER: Rachel Ann Locke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Arnetta Alston (Sister)
(Address): 824 N. Bond Street

15 Filed ..... 19..... Robert F. Harrison, Registrar
Burial Permit Clerk.

P3 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 1st - 1924

17 I HEREBY CERTIFY, That I attended deceased from ..... , 19..... , to ..... , 19..... ,
that I last saw h... alive on ..... , 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... , M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/4 1924
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Mad st

IMPORTANT—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S address should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39946

CERTIFICATE OF DEATH.

100 D 39946

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Bond ST., 7 WARD)

2-FULL NAME Elnora Pulsman

(a) RESIDENCE NO. 614 N. Bond ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem'l	colrd	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		13 mo.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Reeves

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Helen Pulsman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Helen Pulsman
(Address) 614 N. Bond St.

15 Filed SEP 3 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-24 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-1- , 1924 to 9-2 , 1924, that I last saw her alive on 9-1- , 1924 and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Butler, M. D.

, 19 (Address) 253 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Sept. 3 1924

20 UNDERTAKER Wm J. G. Locks ADDRESS 1302 Pa.

R.B. WRITE DISTINCTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Winston Ave-Govanstown St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Thomas Worthington Brundige

(a) Residence No. Winston Ave-Govanstown St., 27 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? 77 yrs. 5 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Meta B. Brundige

6-DATE OF BIRTH (month, day and year) March 30-1847

7-AGE.	If LESS than 1 day,
77 yrs. 5 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Attorney 042

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Law

(c) Name of employer...Thomas W.Brundrige

9-BIRTHPLACE (city or town)..... Baltimore.....
(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER, Thomas V.Brundige

11-BIRTHPLACE OF FATHER (city or town)... Baltimore...
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret T.Smith

13-BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or Country), Md.

14- (Informant) Mr Thomas W. Brundige Jr.
(Address) Winston Ave-Govanstown

15- Filed ...SEP 3 - 1924..., Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sep-1-1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 ....., 19 24, to Aug 31 ....., 19 24,

that I last saw him alive on Aug 31, 19 24,

and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Geo H. Hocking, M. D.

9/1, 19 24 (Address) 5835 Gwynn Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St Johns P.E. Cemetery	Sept 4, 19 24
20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	ADDRESS 108 W. NORTH AVE.

Burial Permit Clerk

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to fill in all items carefully. Exact statement of OCCUPATION is very important. Causes of death must be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89948

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3004 St.Paul St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Regina Fouch

(a) Residence No. 3004 St.Paul St., 12 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? 55 yrs. 10 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm.M.Fouch

6-DATE OF BIRTH (month, day and year) About Oct.12-1869

7-AGE, About, 55 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer..... None

9-BIRTHPLACE (city or town)..Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John E.Haggarety

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eliza A.Hamilton

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) Mr.William M.Fouch(husband)

(Address) 3004 St.Paul Street.

15-

Filed SEP 8 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from May 23rd, 1924, to Sept 1st, 1924, that I last saw h.e alive on Sept 1st, 1924, and that death occurred, on the date stated above, at 3.15 A.m.

The CAUSE OF DEATH* was as follows: /

Angina Pectoris

.....(Duration).....yrs. ? mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? nu Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) A.H.Harriman, M. D.

, 19 (Address) 516 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem.	Sept. 4, 1924
20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Proprietor)	ADDRESS [redacted]

Should be carefully supplied. AGE should be stated EXACTLY as near as can be ascertained. Exact statement of OCCUPATION is very important. Cause of death should be stated in plain terms, so that it may be properly classified. Extra sheet of instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89949 HEALTH DEPARTMENT—CITY OF BALTIMORE D 89949

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 Merryman Court St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Augustus Sauerwein

(a) Residence No. 5 Merryman Court St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? 83 yrs. 4 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Taylor

6-DATE OF BIRTH (month, day and year) May-1-1841

7-AGE, 83 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Peter Sauerwein

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Rech Borge

13-BIRTHPLACE OF MOTHER (city or town) Phila (State or Country), Penna

14- (Informant) E. G. Sauerwein Son

(Address) 5 Merryman Court

15- Filed 1924 Robert P. Harrison, Registrar.

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 2/24

17- I HEREBY CERTIFY, That I attended deceased from Nov ..., 1923, to Sept 2 ..., 1924, that I last saw h... alive on Sept 2 ..., 1924, and that death occurred, on the date stated above, at 8.10 ....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ....yrs. 9 mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. B. Gamble, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery DATE OF BURIAL, Sept 5 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

Exact statement of OCCU... should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

P3

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89950

CERTIFICATE OF DEATH.

D 89950

1-PLACE OF DEATH

Registered No. 15 47

City of BALTIMORE: (No. 3512 Clifton Av St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Augusta Rodenmayer

(a) Residence No. 3512 Clifton Av St., ... Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? 55 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) May-12-1869

7-AGE, 55 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Francis I. Rodenmayer

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary E. Howard

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Miss Bertha E. Rodenmayer Sister

(Address) 3512 Clifton Av

15- Filed ....., 19.. Robert P. Harrison, Registrar.

P 3 1924

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2-1924

17- I HEREBY CERTIFY, That I attended deceased from August, 1923, to Sept 1, 1924, that I last saw h.e alive on Sept 1, 1924, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mammory Gland

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) General Metastases

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes No Date of Aug-1923

Was there an autopsy? .....

What test confirmed diagnosis? Microscopic

(Signed) Standish McCleary, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, Sept 4, 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. North Ave.

THE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1019 S. Clinton St. 76 St., 44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Wenger

(a) Residence No. 1019 S. Clinton St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Crezenz Wenger

6-DATE OF BIRTH (month, day and year) Aug 31- 1864

7-AGE. 60 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)... Steel
(c) Name of employer...

9-BIRTHPLACE (city or town)..... (State or Country). Germany.

PARENTS.

10-NAME OF FATHER, Joseph Wenger

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Victoria Frei.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany.

11- (Informant) Victoria Wenger

(Address) 1019 S. Clinton St.

15- Filed SEP 3 - 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 19 24 to Sept 2 19 24

that I last saw h.. alive on Sept 1 19 24

and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

Carcinoma Liver

(Duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?... Unknown

Did an operation precede death?... No Date of

Was there an autopsy?...

What test confirmed diagnosis?... X Ray

(Signed) Fred Ruhstaller M. D

19 24 (Address) 1000 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL. Sept. 5 1924

20-UNDERTAKER. Lilly & Julius ADDRESS 403 S Wolfe St.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Habicht

(a) Residence No. ~~Fullerton, Maryland~~ 25 S. Highland Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Habicht.

6-DATE OF BIRTH (month, day and year) Jan. 3 -

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework.

(b) General nature of industry, business, or establishment in which employed (or employer). at home.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, John Frank

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ger.

14- (Informant) Rudolph Habicht

(Address) 25 S. Highland Ave.

15- Filed SEP 3 - 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15 1924 to Sept 1 1924 that I last saw h.. alive on Sept 1 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostasis

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. & Phys. Exam

(Signed) J. A. Entelmann M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. Sept 4, 1924

20-UNDERTAKER. Lilly and Zeiler ADDRESS 403 S. Wolfe St.

Burial Permit Clerk

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4944 Vermont Ave WARD 27)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie B Shryock

(a) RESIDENCE No 4944 Vermont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. Fuller Shryock

6 DATE OF BIRTH (month, day, and year) Oct 7 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo M Forney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ellen K Bixby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry L Shryock
(Address) 4701 Roslyn Ave

15 Filed SEP 3 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J Morrissey, M. D.
(Coroner.)

Sept 2, 1924 (Address) 3132 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Sept 4 1924
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89954

CERTIFICATE OF DEATH.

D 89954

185

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off Fort Armstead, Hawkins Point (WARD) 21

2-FULL NAME William A. Walker.

(a) RESIDENCE No. 1007 Ridgely St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of Elizabeth Walker.

6 DATE OF BIRTH (month, day, and year) April 22, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John W. Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Mitchell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George E. Walker. (son)
(Address) 20 Southern Ave.

15 Filed SEP 3 - 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Concussion of the Brain, Fracture of the Spine, Diving from a pier into shallow water. Accidental death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Sep. 1, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edward L. Cedar Hill Cem.	Sept 3 1924
20 UNDERTAKER	ADDRESS
Edward L. Fanning & Son	Lafayette Washington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. Seldner 1501 E. Eager St

D 89955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1747 E. Lanvale St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rosenthal

(a) Residence No. 1747 E. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Rosenthal

6-DATE OF BIRTH (month, day and year) Dec 17 1864

7-AGE. 59 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER Joseph Zeis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Susanna Brilhart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Hilda Holmes

(Address) 1747 E. Lanvale St.

15- Filed SEP 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1924 to Sept 1 1924

that I last saw h[illegible] alive on Sept 1 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) M. D.

1924 (Address) 501 E. Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Sept. 4. 1924
20-UNDERTAKER.	ADDRESS
H. Sander's Sons	710 Fleet St

All blanks should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1741 24 89956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1741 89956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Strange

(a) RESIDENCE NO 1603 Front St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1890

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Barney Siegel

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah Cohen

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed P3 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1924, to Sept 1, 1924, that I last saw her alive on Sept 1, 1924, and that death occurred, on the date stated above, at 11 00 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Acute Purulent Peritonitis
(Cause not determined)
(even at autopsy)

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Bilateral Empyema

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no. Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Geo H Gardner M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9/4/24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ca ave

NOTE.—WRITE LEGIBLY. Use only black ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17448 2 D 89957

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89957

CERTIFICATE OF DEATH.

REGISTERED NO. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene J Bozette

(a) RESIDENCE NO. Goldsboro N. C. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: John J Bozette

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Maggie Summerfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 ..... Registrar

P3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 31 - 1924. to Sept 2 - 1924.

that I last saw alive on Sept 2 - 1924.

and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Spinal cord tumor

(duration) ..... yrs. 15 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N. C

Did an operation precede death? Yes Date of Sept 2 '24

Was there an autopsy? Yes

What test confirmed diagnosis? Path. exam

(Signed) Warfield M. Firor M. D.

Sept 2 1924 (Address) Johns Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gatesboro N C — DATE OF BURIAL: Sept 3 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

FILL.—WRITE PLAINLY. PHYSICIANS' attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS' attention should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION may be properly classified

Cor.—1-12-23—M&T—100 Bks.

D 89958

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 89958

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 S Spring ST. 3 WARD)

2-FULL NAME Baby Randolph

(a) RESIDENCE No. 304 S Spring ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			one	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Salt Lk
(State or country)

PARENTS

10 NAME OF FATHER Virgil Randolph

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Viola Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Virgil Randolph
(Address) 304 S Spring St

15 Filed ..... 192 .....
Registrar

1739

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foramen Ovale
Immaturity

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Taylor M. D.
(Coroner.)

Sept 2, 1924 (Address) 708 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Sept 3 1924

20 UNDERTAKER: Commissioner of Health.

ADDRESS .....

For Wm. R. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are necessary. TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nellie Clem

(a) Residence No. Elkridge, Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Clem

6-DATE OF BIRTH (month, day and year) 1896

7-AGE, 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Elkridge. Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " " "

14- Ernest Clem
(Informant)
(Address) Elkridge, Md

15- Filed SEP 3 - 1924 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-3-24

17- I HEREBY CERTIFY, That I attended deceased from 9-2 19 24 to 9-3 19 24

that I last saw her alive on 9-3 19 24

and that death occurred, on the date stated above, at 8 05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

Cerebral (Duration) yrs. mos. 24 hrs.
CONTRIBUTORY (Secondary) Eclampsia
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination again

(Signed) Lewis J. Beuler M. D

, 19 (Address) Elkridge Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustine Cemetery	9-5, 192
20-UNDERTAKER	ADDRESS
Carpenter & Stiffler	Elkridge Md

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89960

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2017 Longwood St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E. Ambrose

(a) Residence No. 2017 Longwood St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis J. Ambrose

6-DATE OF BIRTH (month, day and year) May 31. 1871

7-AGE 53 yrs. 5 mos. 2 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country) Easton, Md

PARENTS.

10-NAME OF FATHER Elias E. Dumbaugh

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Easton. Md

12-MAIDEN NAME OF MOTHER Anna Mathews

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country) Easton, Md

14- (Informant) Louis J. Ambrose

(Address) 2017 Longwood

15-

Filed Robert P. Harrison, Registrar

P3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-2-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 17, 1924 to Sept 2, 1924

that I last saw h alive on Sept 2, 1924

and that death occurred, on the date stated above, at 10.00 A. M.

The CAUSE OF DEATH* was as follows:

Chronic. My occurdates

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Collins M. D.

9/3/24 (Address) 2737 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery Baltimore

DATE OF BURIAL Sept 4 1924

20-UNDERTAKER. J. B. Hepburn

ADDRESS 1850 N. Gilmor St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89961 D 89961

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital 00 ST., WARD)

2-FULL NAME Oscar Saage

(a) RESIDENCE No. 2007 Wilkens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Saage

6 DATE OF BIRTH (month, day, and year) Sept 16th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wilson & Matson

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Saage (Address) 313 E. Lanvale

15 Filed ..... 19 .....

Robert P. Harrison, M.D.
Registrar
Burial Permit Clerk.

SEP 3 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1- 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15- , 1924, to Sept-1- , 1924, that I last saw him alive on Sept 1- , 1924 and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) uremia

, (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) Edw Emerson M. D.

9/1, 1924 (Address) 817 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL Sept 4 1924

20 UNDERTAKER F B Keppert ADDRESS 1850 N. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT... AGE should be stated EXACTLY. PHYSICIANS... mation should be carefully supplied. Accurate... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec--12-23-21--E.B.R.S.--400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89962 ✓ D 89962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No 205 S. 5th St., No Ward) 9

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincenzo Nino Natale

(a) Residence No. 205 S. 5th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Baby Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6-DATE OF BIRTH (month, day and year) April 15. 1924

7-AGE. .....yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Vito Natale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Gelsomina D'Marco

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

11- (Informant) Vito Natale

(Address) 205 S. 5th St.

15- Filed SEP 3 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 2 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1924 to Sept 2 1924.

that I last saw him alive on Sept 1 1924.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Probably Whooping Cough

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Robt P. Green M. D.

9-3 -, 1924 (Address) 120 Aisquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oaklawn Cem. DATE OF BURIAL. 9/3/24 19..

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Harford Ave

should be carefully supplied. AGE should be stated EXACTLY. Entries should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39963

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 39963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1931 Frederick Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malcolm Tebbs Jr

(a) Residence No. 1421 W Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 16-1922

7-AGE, 1 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Malcolm Tebbs Jr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Rachel Kelborne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mr Malcolm Tebbs

(Address) 1931 Fred Ave

15- Filed SEP 3 - 1924 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 24 to Sept 2, 19 24

that I last saw h/m alive on Sept 2 19 24

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Odema of Lungs

(Duration) yrs. mos. 1 ds.

If-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Law V Berdahuer M. D.

, 19 (Address) 2 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville Cemetery DATE OF BURIAL Sept 4 19 24

20-UNDERTAKER. John F Cowan & Son ADDRESS 908 Walbert Ave

per Chas F J Cowan

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89964

CERTIFICATE OF DEATH.

F 129 D 89964

1-PLACE OF DEATH Franklin Sq. Hospital 14

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Garland, Lowe

(a) RESIDENCE NO. Tilghmans Island ST., Md. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 -1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. L. Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline F. Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W.H. Seamon Jr.
(Address) Mt Dimick Ave

15 Filed SEP 4 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3- 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug-27-, 1924, to Sept 3, 1924, that I last saw her alive on Sept 3, 1924, and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Cystic Calculus

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. D. Parr, M. D.

9/3/ 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michaels, Md.

DATE OF BURIAL Sept 5, 1924

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS DATE should be stated EXACTLY. PHYSICIANS should write information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89965 — 1290 89965

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1232 N. Arlington Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Jones

(a) RESIDENCE No. 2232 N Arlington Ave ST., WARD

(Usual place of abode) about 9

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie L. Jones

6 DATE OF BIRTH (month, day, and year): March 3, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	38	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ala

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Mary Smith
(Address) 232 N. Arlington Ave

15 Filed SEP 4 1924, 19 — ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 19 24, to Sept 2, 19 24.

that I last saw h[illegible] alive on Sept 2, 19 24.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. F. Hatchett, M. D.

9/3, 19 24 (Address) 1226 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: Sept 5 19[illegible]

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 52 W Lombard

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 39966

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 39966

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Gibbs Wharf No. 1

CITY OF BALTIMORE: (No. 2303 Boston ST., WARD)

2-FULL NAME Wilmer T. Harmon

(a) RESIDENCE No. 2212 Cambridge ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2e yrs. mos. ds. How long in U. S., if of foreign birth? 2y yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gibbs Packing Co

9 BIRTHPLACE (city or town) Berlin
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Harmon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma James

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John C. Long
(Address) 2211 Cambridge St

15 Filed SEP 4 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning fell from Gibbs wharf while he was working

(duration) ..... yrs. Embolism

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFaulden, M. D.
(Coroner.)

Sept 4 1924 (Address) 700 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Berlin Md.	Sept 5 1924
20 UNDERTAKER Lilly & Zeiler Co	ADDRESS 403 So Wolfe St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Burial cannot be allowed by Undertaker or Sexton unless this certificate is filled out and signed.

Spec—12-23-21—E.E.R.S.—400 Blks.

D 89967

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 39967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 520 N. Castle St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret D. Smith

(a) Residence No. 520 N. Castle St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late Jos. T. Smith

6-DATE OF BIRTH (month, day and year) Feb 3 1863

7-AGE. 61 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, John Schefflein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret -

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Clara B. Klausmeyer

(Address) 520 N. Castle St

15- Filed SEP 4 1924 ROBERT R. KRAUTER, Burial Permit Clerk, 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 1/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1924 to Sept 1 1924

that I last saw her alive on Sept 1 1924

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Acute Mitral Regurgitation

acute Nephritis

Hypertension

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical B.P.

(Signed) Fred Runcoa M. D.

9-3 1924 (Address) 800 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 9/4/24

20-UNDERTAKER Philip Herwig — ADDRESS 206 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D 89968

D 89968

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 N. Central Ave ST., 10 WARD)

2-FULL NAME Sophia Niebergall

(a) RESIDENCE NO. 1016 N. Central Ave ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Niebergall

6 DATE OF BIRTH (month, day, and year) Dec. 20 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
In Yrs	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Frederick Belz
(Address) 1016 N. Central Ave.

15 Filed SEP 4 1924 . 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 8th, 1924, to Sept 3rd, 1924, that I last saw h[illegible] alive on Sept 3rd, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Uremia Tolerans

Coma Day Officially

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Bing, M. D.

(Address) 1301 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 5 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 39969 — 113 ✓ — D 39969

REGISTERED No. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 W. Lee ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William William Mc Daniel Jr.

(a) RESIDENCE No. 638 W. Lee ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar - 14 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William Mc Daniel Jr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes V. Brooks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant William Mc Daniel Jr.
(Address) 638 W Lee St

15 Filed SEP 4 1924, 19 ROBERT A. KRAUTER, Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 3 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug - 16, 19 24, to Sept, 3, 19 24,

that I last saw him alive on Sept, 2, 19 24,

and that death occurred, on the date stated above, at 12 10 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea + Enteritis

(duration) — yrs. — mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan Franklin, M. D.

9/3, 19 24 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Sept 4 1924
20 UNDERTAKER	ADDRESS
J. F. Brown & Son	W'mport

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 39970 HEALTH DEPARTMENT—CITY OF BALTIMORE D 39970

CERTIFICATE OF DEATH.

7 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 523 N. Curley St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph F. Keller

(a) Residence No. 523 N. Curley St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Keller

6-DATE OF BIRTH (month, day and year) Jan. 18. 1854

7-AGE. 69 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machine tender

(b) General nature of industry, business, or establishment in which employed (or employer) Paper making

(c) Name of employer..... Gilbert Goodfellow

9-BIRTHPLACE (city or town) (State or Country). Balto. Co. Md

PARENTS.

10-NAME OF FATHER. Geo. W Keller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Co. Md

12-MAIDEN NAME OF MOTHER. Comfort Tracey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Co. Md

14- (Informant) Barbara Keller

(Address) 523 N. Curley

15- Filed SEP 4 1924 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 2-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1922 to Sept 2 1924 that I last saw him alive on August 15 1924 and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests

(Signed) J. M. Dilcutt M. D.

Sept 2. 1924 (Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery DATE OF BURIAL. Sept 5. 1924

20-UNDERTAKER. E. Le Roy Stuffler ADDRESS 125 E Mulberry

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

89971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001

D 89971

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Jones

(a) Residence No. 1019 N. Carlton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). ?

(State or Country).

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town). ?

(State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). ?

(State or Country).

14-

(Informant) Municipal Hospital Records

(Address)

15-

Filed SEP 4 - 1924 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-2-24

17- I HEREBY CERTIFY, That I attended deceased from 8-23, 1924 to 9-2, 1924

that I last saw her alive on 9-1, 1924

and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Cerebral Hemorrhage

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Brace, M. D.

9-3, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet. DATE OF BURIAL, 9-6, 1924

20-UNDERTAKER. Dan'l Easton. ADDRESS 916 Penna. Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 39972

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D 39972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital Thirty Third St & Calvert ST., 21 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doris Franklin

(a) RESIDENCE NO. 712 W West ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 8, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ernest Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Lois Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Parents -- Same address

15 Filed ....., 19..... Registrar

SEP 4 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1924

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to Sept 3, 1924, that I last saw h[illegible] alive on Sept 3, 1924, and that death occurred, on the date stated above, at 6:25 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(durntion) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) .....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Austin Quarre M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Sept 4 1924

20 UNDERTAKER Jos Foerderer Son

ADDRESS 2173 Pa

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in making their certificates. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should use plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 89973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89973

CERTIFICATE OF DEATH. 198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Sapp. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Gainey

(a) RESIDENCE NO. 507 Sapp. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colod	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: labor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER Joseph Gainey

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER Lester Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Jane Hill
(Address) 507 Sapp St

15 Filed SEP 4 1924 192 Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Autopsy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular Staph
Left Side Lower Abdominal
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Geo. Edward Pfeiffer, M. D.
(Coroner.)
Aug 31 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 4 1924
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89974

CERTIFICATE OF DEATH.

1/4 D 89974

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Spring St., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Lee.

(a) RESIDENCE NO. 413 — N Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cordelia Ashby

6 DATE OF BIRTH (month, day, and year) Aug. 31—1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto —

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frank Richardson (Address) 413 N. Spring St.

15 Filed , 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-24 19

17

I HEREBY CERTIFY, That I attended deceased from 8-26-24, 19 to 9-1-24, 19,

that I last saw him alive on 9-1-24, 19,

and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 2531 Guilford St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 4 1924
20 UNDERTAKER	ADDRESS
Jos. T. H. Rochester	1413 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should be careful in stating the CAUSE OF DEATH. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 4 1924

Spec.—1-12-23—M&T—500 Bks.

D 89975

HEALTH DEPARTMENT—CITY OF BALTIMORE D 89975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 349 S Mount St. ST., 14 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Huss

(a) RESIDENCE NO. 349 S Mount St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Huss

6 DATE OF BIRTH (month, day, and year) March 17, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Booze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Carl Huss (Address) 349 S Mount St

15 Filed SEP 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3. 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept 3, 1924, that I last saw her alive on Sept 3, 1924, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephrites

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerbral Hemorrhage 3 days
Odema of Lungs 1 day

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan, M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 6 1924
20 UNDERTAKER John J. Fields	ADDRESS 1200 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89976

CERTIFICATE OF DEATH.

113

D 89976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univerity Hospital St. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J Madden

(a) RESIDENCE No 1122 Ward's ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Vernon R Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Grace A Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Vernon R Maddan
(Address) 627 Ward St

15 Filed SEPT - 1924 492 Robert P. Harrison, Registrar
Burial Permit Crmk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Tooth Extraction

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Heart & Duct

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Grinnell M. D.
(Coroner)

9-3 1924 (Address) 1122 Ward St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 5 1924

20 UNDERTAKER John J Fields ADDRESS 1200 W Fayette

IMPORTANT—Should be clearly written. Avoid abbreviations. Exact statement of OCCUPATION should be made. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 89977

HEALTH DEPARTMENT—CITY OF BALTIMORE

1130 89977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Oakland ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F Dorsey

(a) RESIDENCE NO. 1216 Oakland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1923

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or....min.
1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael F Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Michael F Dorsey

(Address) 1226 N Oakland

15 Filed SEP 4 1924, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/1/, 1924, to 9/4/, 1924, that I last saw h[illegible] alive on 9/4/, 1924, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Improper Feeding

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilfred Brum, M. D.

, 19 (Address) 1217 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Sept 6 1924

20 UNDERTAKER John J Fields — ADDRESS 1201 W Lanvale

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89978

CERTIFICATE OF DEATH.

151 D 89978

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 Walnut St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Charles Harris

(a) Residence No. 544 Walnut St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Winters

6-DATE OF BIRTH (month, day and year) Oct 28 1897

7-AGE. 27 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Samuel Harris

11-BIRTHPLACE OF FATHER (City or Town) (State or Country) Md France

12-MAIDEN NAME OF MOTHER, Georgia Hodges

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country) Md Moore

14- (Informant) Georgia Williams

(Address) 945 Pacific

15- Filed Sept 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 3-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept 3, 1924, that I last saw him alive on Sept 3, 1924, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene left leg

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8-10-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H N King M. D.

, 19 (Address) 625 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Auburn	9/6/24
20-UNDERTAKER. David Easton	ADDRESS 916 Pacific

Be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See directions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89979

CERTIFICATE OF DEATH.

D 89979

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. Poppleton ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Thomas,

(a) RESIDENCE NO. 3 N. Poppleton, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 7 1923

7 AGE: Years | Months: 9 | Days: 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Non

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Davies Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lennie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Davies Thomas

(Address): 3 N Poppleton St

15 Filed SEP 4 - 1924, 19 Robert J. Harrison Registrar

Daniel Dermit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 3. 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 1924, to Sept 3rd, 1924, that I last saw him alive on Sept 2nd, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Measles

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam

(Signed) Thos Horton, M. D.

9/3/24 (Address) 888 W Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn

DATE OF BURIAL: 9/4/ 1924

20 UNDERTAKER: R B Good 1405 W Eldery

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES ON THIS CERTIFICATE should be carefully supplied. AGE, PLACE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39980

CERTIFICATE OF DEATH.

129

D 39980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2110 Maryland Ave (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Taylor Hooton

(a) RESIDENCE NO. 2110 Maryland Ave (ST.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Hooton

6 DATE OF BIRTH (month, day, and year) May-9-1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Nsme of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Chas. Hooton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Annie E Hooton (Address) 2110 Maryland

15 Robert P. Harrison, Registrar

SEP 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Sept 2, 1924, that I last saw him alive on Sept 1, 1924, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin F. Vogel M. D.

9/3, 1924 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 4 1924
20 UNDERTAKER	ADDRESS
H. C. Tickner & Son	North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39981

CERTIFICATE OF DEATH. 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St., Ward D Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Smith

(a) Residence No. 136 Ray Towng 837 Ray St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1849

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) Bay View Hospital Ward A.

15- Filed SEP 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-1-24

17- I HEREBY CERTIFY, That I attended deceased from 8-30, 19.24 to 9-1, 19.24

that I last saw h. alive on 9-1, 19.24

and that death occurred, on the date stated above, at 1A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Multiple metastases

12 hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/30/24

Was there an autopsy? No

What tests confirmed diagnosis? Clinical & Lab. Tests

(Signed) Wm. P. Chandler M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL, 19...

20-UNDERTAKER. Commissioner of Health.

ADDRESS SEP 4 - 1924

Per Wm. P. McCALL.

N. B.—WHITE PAPER, WRITE ONLY. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Be in plain terms, so that it may be properly classified.

STATE OF MARYLAND.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

174 D 39982

CERTIFICATE OF DEATH.

161-001 D 39982

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., WARD 1

2-FULL NAME Girl Smith

(a) RESIDENCE NO. St. Vincents Infant ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Lyd. F mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	?	?	abt 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records (Address) John Hopkins Hospital

15 - 1924 Robert P. Harrison, Registrar
19 1743
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from August 13, 1924 to August 15, 1924, that I last saw h[illegible] alive on August 15, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edmund A Kemp, M. D.

Dec 19 24 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

For Wm. A. Wood(illegible)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P4 26

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89983

CERTIFICATE OF DEATH.

129

D 89983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1827 N Dallas ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A Engle

(a) RESIDENCE No. 1827 N Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug 23rd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charlestown W Va

PARENTS

10 NAME OF FATHER Beverly Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Bernevia McKnight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kanawha

14 Informant Katie Engle

(Address) 1827 N Dallas st

15. Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Sept 2, 1924, that I last saw him alive on Sept 2, 1924, and that death occurred, on the date stated above, at 7:10 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic nephritis + arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? None.

What test confirmed diagnosis? None

(Signed) J. A. Bowden, M. D.

9/4, 1924 (Address) 1517 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W Va	Sept 5th 1924

20 UNDERTAKER A. Jones

ADDRESS W Va

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

P4 1924

D 89984

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 89984

HEALTH DEPARTMENT—CITY OF BALTIMORE

51

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N. Stricker ST.; WARD) 11

2-FULL NAME Alice Scott

(a) RESIDENCE. NO. 419 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days
	67		

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Annie Robinson.

(Address) 419 N. Stricker St.

FEB 1924 19 Robert P. Harris M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1924, to Sept 3rd, 1924, that I last saw her alive on Sept 2nd, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) F. B. Lynch, M. D.

Sept 3-24 (Address) North Ave & Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Sept 5th 1924

20 UNDERTAKER J. Jones ADDRESS 111 S. Gilmor St.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be careful mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 39985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39985

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 1819 Bolton St., Ward 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Sue Dunkel

(a) Residence No. 1819 Bolton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Irvine T. Dunkel

6-DATE OF BIRTH (month, day and year) March 1857

7-AGE. 67 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Howard Co Md

PARENTS.

10-NAME OF FATHER. Charles R. Pue

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Emily Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Howard Co Md

14- (Informant) Mrs Irvine T. Dunkel

(Address) 1819 Bolton St.

15- Filed SEP 4 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 11th 1924 to Sept. 3 1924

that I last saw h[illegible] alive on Sept. 3 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic infection of gall bladder (Cholecystitis)

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1916.

Was there an autopsy? yes.

What test confirmed diagnosis? None.

(Signed) Harry S. McCarty, M. D.

9-4, 1924 (Address) 37 W Preston Street.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Johns Cem

DATE OF BURIAL. Sept 5, 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 1201 W Fayette St

McCarty - 37 W Preston St

NOTE—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 89986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 89986

1-PLACE OF DEATH Hospital for Women of Md.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette Ave & Johns Hopkins ST., ... WARD)

2-FULL NAME Mary Mae Schlossel

(a) RESIDENCE NO. 526 N. Charles ST., ... WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-21-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	49	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Strasser

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Schlossel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Victoria Hemmelgarn

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Geo Schlossel (Address) 501 E 39th St

15 SEP 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1924

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1924 to Sept 4, 1924.

that I last saw her alive on Sept 3, 1924

and that death occurred, on the date stated above, at 12 55 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 526 N. Charles.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Kenneth B. Boyd, M. D.

9/4, 1924 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Sept. 5 1924

20 UNDERTAKER Chas F. Truesdow

ADDRESS 118 West Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Hennessy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89987

D 89987

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1323 Park Ave ST., ... WARD)

2-FULL NAME Dr Charles Edwin Dennis

(a) RESIDENCE No 1323 Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie H Dennis

6 DATE OF BIRTH (month, day, and year) May 28, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) New Jersey.

PARENTS

10 NAME OF FATHER Lord Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Sarah Risley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey.

14 Informant Annie Dennis (Address) 1323 Park Ave.

15 Filed SEP 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Sept. 4, 1924 (Address) 2 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 5 1924

20 UNDERTAKER J. C. Cook — ADDRESS 502 E Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39988

CERTIFICATE OF DEATH.

40 D 39988

1-PLACE OF DEATH West Baltimore General Hospital.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Rayner & Dulaney ave ST., WARD)

2-FULL NAME Mrs. Mazewell E. Poulson

(a) RESIDENCE NO. 1041 Myrtle Ave. ST., WARD.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mr. Randolph Poulson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Onancock
(State or country) Virginia.

PARENTS

10 NAME OF FATHER Robert Joynes

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Etherie Wise

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mr. Randolph Poulson
(Address) 1041 Myrtle Ave.

Filed SEP 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1924, to Sept 3rd, 1924, that I last saw her alive on Sept 3rd, 1924, and that death occurred, on the date stated above, at 1:50 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Tubo-Ovarian abscess

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism.

(duration) yrs. mos. 4 hrs.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Sept 2nd 1924

Was there an autopsy? no

What test confirmed diagnosis? Confirmed clinically.

(Signed) Clement R. Monroe, M. D.

. 19 (Address) West Baltimore General Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Onancock V.A.

DATE OF BURIAL 9/5/24 19

20 UNDERTAKER David Easton

ADDRESS 916 Race

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89989

CERTIFICATE OF DEATH.

113 D 89989

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 Aliceanna St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kolodziejski

(a) Residence No. 1607 Aliceanna St., Ward.....
(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 31 1923

7-AGE. ...yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Stephen. Kolodziejski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Mary. Mierkiewicz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Mrs. Mary Kolodziejski

(Address) 1607 Aliceanna Street

15- SEP 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sep. 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1924 to Sept. 4th, 1924 that I last saw h[illegible] alive on Sept 4 1924 and that death occurred, on the date stated above, at 6 20 A m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 1 mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger M. D

19 (Address) 1709 Aliceanna St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Sept. 5 1924 19

20-UNDERTAKER. John M. Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT—should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89990

CERTIFICATE OF DEATH. 91-002D 89990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4329 Rickford Rd. ST., 21 WARD)

2-FULL NAME Mrs Sarah Ella Pitcher

(a) RESIDENCE NO. 4329 Rickford Rd ST., 21 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life 69-6 mos. 1 ds. How long in U. S., if of foreign birth? 69 yrs. 6 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Reese Pitcher

6 DATE OF BIRTH (month, day, and year) Mch 2 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	69	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm H. Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Martha A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant J. Reese Pitcher

(Address) 4329 Rickford Rd

15 Dated SEP 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1924

17

I HEREBY CERTIFY, That I attended deceased from ——— , 1919 , to Sept 3 , 1924 , that I last saw her alive on Sept 3 , 1924 , and that death occurred, on the date stated above, at 4.20 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis yrs C.

Embolism (duration) yrs. mos 29 ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) William E. Todd M. D.

1924 (Address) Mt Washington Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Sept 5 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 89991

89991

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calesela Conway (Conaway)

(a) Residence No. 525 Bloom st. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Conway

6-DATE OF BIRTH (month, day and year) 1899

7-AGE. 25 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Albert Wood

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- SEP 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 13 1924 to Sept. 1 1924

that I last saw her alive on Sept. 1 1924

and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) J. Justice M. D.

9-2-. 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lancaster Co Va Morrys Point

DATE OF BURIAL. Sept 5 1924

20-UNDERTAKER. Virginia A. Brooks

ADDRESS 1463 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89992

CERTIFICATE OF DEATH.

117 D 89992

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital Ward A. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Stepney

(a) Residence No. 537½ Greenmiller St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1895

7-AGE. 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 410

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Baltimore, Md.

PARENTS:

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town). (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Jones (?)

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Maryland

14- (Informant) Hospital Record

(Address) Bay View Hospital

15- Filed SEP 5 - 1924 ROBERT N. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/3/24

17- I HEREBY CERTIFY, That I attended deceased from 8/31, 1924 to 9/3, 1924

that I last saw h. alive on 9/3, 1924

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis 8 hrs.

Subacute appendicitis. 2 weeks.

acute Intestinal obstruction 8 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Operative Shock 6 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 9/3/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab. M.D.

(Signed) J. C. Crampton M.D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn St. | DATE OF BURIAL, Sept 6, 1924

20-UNDERTAKER, J. S. L. Brown's Son | ADDRESS 1017 W. Mount St.

INK—THIS IS A PERMANENT RECORD. Every item of information TE PLAINLY, WITH UNFADING INK. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 89993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 89993

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1926 Gough St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Doris Young

(a) Residence No. 1926 Gough St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 15. 1923

7-AGE. yrs. 11 mos. 20 ds.

If LESS than 1 day, hrs. or. mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Kenneth Young

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Ethel Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

11- (Informant) Ethel Young

(Address) 1926 Gough St

SEP 5 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 5. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1924 to Sept 5th 1924

that I last saw her alive on Sept 4th 1924

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) 5 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Weibel M.D.

9/5, 1924 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem.	Sept 6, 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Pleasant

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 39994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 39994

CERTIFICATE OF DEATH.

X 38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., ... WARD)

2-FULL NAME Mattie Pasco

(a) RESIDENCE No. 633 N. Paca ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 010

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno Payne.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ida. adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mercy Hospital

(Address) Mitch Keyser Blvd.

15 SEP 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/24

17

I HEREBY CERTIFY, That I attended deceased from 8/28/24, 19..... to 9/1/24, 19 ,

that I last saw h alive on 9/1/24, 19 ,

and that death occurred, on the date stated above, at 7.45 8 m.

The CAUSE OF DEATH* was as follows:

Lues.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) aortic Aneurysm.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Necropsy

(Signed) A. W. DeCay, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Andrews Cem	Aug 5 1924
20 UNDERTAKER Brown & Ireland	ADDRESS 11 W Lexington St

MARGIN RESERVED FOR GOVERNMENT RECORD.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89995

CERTIFICATE OF DEATH.

100 - 001 D 89995

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 E-Federal St ST., ... (WARD)

2-FULL NAME Frank Herman Onken

(a) RESIDENCE NO. 2113 E-Federal ST., WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie H. Onken nee Kaas

6 DATE OF BIRTH (month, day, and year) Mar 9, 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brewer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Reinhardt Onken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hanna Thums

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie H Onken

(Address) 2113 E Federal St

15 Filed SEP 5 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1924, to Sept. 2, 1924.

that I last saw him alive on Sept 2, 1924.

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & acute Dilat

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Terminal (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) S. W. Worley M. D.

, 19 (Address) 1817 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 5 1924
20 UNDERTAKER Harry H Nitzke	ADDRESS 1531 Monday

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 89996

CERTIFICATE OF DEATH.

90 D 89996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Smith ST., WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Golden

(a) RESIDENCE NO. 1214 Smith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. T. Golden

6 DATE OF BIRTH (month, day, and year) about 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas. T. Golden
(Address) 1214 Smith St.

15 Filed SEP 5 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) .... yrs. 9 mos. .... ds.

CONTRIBUTORY (Secondary) no history.

(duration) .... yrs. .... mos. .... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Sept. 4, 1924 (Address) 202 Cambridge Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 5 1924
20 UNDERTAKER John H. Foden	ADDRESS 1027 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 89997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. McCracken

(a) Residence No. Mt Hope Retreat St., 28 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 31-1907

7-AGE, 16 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm J. McCracken

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Bertha Whitten

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Records of Mt Hope Retreat

(Address) Baltimore Md.

SEP 5 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 4-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1924 to Sept 4th, 1924

that I last saw him alive on Sept 3rd, 1924

and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gen. Nuritis - Complicated by Hypostatic Pneumonia.

abt (Duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Mania Psychosis

abt (Duration) 0 yrs. 1 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Sept 4, 1924 (Signed) Frank J. Flannery, M. D. (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Sept 7, 1924

20-UNDERTAKER, Flynn & Fleming ADDRESS Glyndon Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 89998

CERTIFICATE OF DEATH.

21

REGISTERED NO. D 89998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Rose ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. G. Waltz

(a) RESIDENCE NO. 1509 Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Rose

6 DATE OF BIRTH (month, day, and year) July 7, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Professor of Music

(b) General nature of industry, business, or establishment in which employed (or employer): Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Waltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mary F. Waltz (Address) 1509 Rose St.

Filed SEP 6 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1924 to Sept. 2, 1924, that I last saw him alive on Sept. 2, 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos 28 ds.

CONTRIBUTORY (Secondary) - - - - - - -

- - - - (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of - - - -

Was there an autopsy? no

What test confirmed diagnosis? Sputum examination

(Signed) Harry Leibel M.D.

9/4 19 24 (Address) 1224 Hanover Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 9/5 19 24

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1477 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 89999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D 89999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 W. Ostend St. ST., WARD) 8

2-FULL NAME George W. Hill

(a) RESIDENCE NO. 120 W. Ostend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellia Hill

6 DATE OF BIRTH (month, day, and year) Feb. 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Edwin C. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lydia A. Higdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, md

14 Informant Mrs. Nellie Hill

(Address) 120 W. Ostend St.

15 Filed SEP 5 - 1924 19 ROBERT R. KRAL Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1924, to Sept 2, 1924, that I last saw him alive on Sept 2, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

from Contributory (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cushing, M. D.

Sept 2 1924 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Sept. 6 1924

20 UNDERTAKER Margaret H. Flynn — ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90000

CERTIFICATE OF DEATH. X188-113D 90000

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Mem'l Hospital ST.; WARD) 17

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Engel.

(Residence in Baltimore: No. Ft. Howard Md St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Single.

6-DATE OF BIRTH.

?, 1
(Month) (Day) (Year)

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soldier
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Pa

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Emma Engle

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ft Howard

(Address) Md

15-

Filed SEP 5 1924 1924 Robert P. Harrison,
Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 3, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August. (Inquest, autopsy or inquiry.) did that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident
Multiple Fractures
(Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Shock.
(Duration) yrs. mos. ds.

(Signed) Geo Clifford Boteler M. D.
(Coroner.)
Sept 5/24 (Address) 1436 Kenyon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pittsburg Pa.	Sept 5. 1924
20-UNDERTAKER	ADDRESS
Adl Gunson & Bro	Balto Md

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90001

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., Ward 1

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wilkins

(a) Residence No. 803 W. Ostend St., Ward 11

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1851

7-AGE,	If LESS than 1 day,
73 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-

(Informant) Municipal Hospital Records

(Address)

15-

Filed SEP 5 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-3-24

17- I HEREBY CERTIFY, That I attended deceased from 12-8, 19.23, to 9-3, 19.24

that I last saw her alive on 9-2, 19.24

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude G. Broad, M. D.

9-3, 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Int Auburn Cemetery	Sept 6 19 24
20-UNDERTAKER,	ADDRESS
Mrs Geo H. Hooper	1064 Conway St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90002 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90002

CERTIFICATE OF DEATH. X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.M.H. No 1 ST., (WARD)

2-FULL NAME Charles Gardner Lewis.

(a) RESIDENCE NO. Berlin Md R F D No 6 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Lewis

6 DATE OF BIRTH (month, day, and year) June 28 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surfman 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.C. Guard Service

9 BIRTHPLACE (city or town) (State or country) Berlin, Md.

PARENTS

10 NAME OF FATHER Geo. W. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Worcester

12 MAIDEN NAME OF MOTHER Rhoda Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant self. wife

(Address)

15 Filed SEP 5 - 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1924

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1924, to Sept 5, 1924.

that I last saw h— alive on Sept 5, 1924.

and that death occurred, on the date stated above, at 7.00 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis. over

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) acute gastritis.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Postmortem findings

(Signed) M. F. Foley M.D., M. D.

19 (Address) U.S. Marine Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ocean City Md	Sept 5 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Nan

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1738 90003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90003

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

2-FULL NAME Julia Barringer

(a) RESIDENCE NO. 2318 N. Eutaw Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country) New York

PARENTS

10 NAME OF FATHER John McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget O'Malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, M. D.

Registrar

Burial Permit Clerk.

P5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1924

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to Sept 4, 1924, that I last saw her alive on Sept 4, 1924, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculo Bacterial Endocarditis

Complicated by Uraemia

and Bronchopneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Harrison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept 6 1924
20 UNDERTAKER	ADDRESS
J. J. Flynn & Son 1576	Eutaw

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—DO NOT USE PENCIL. DESERVES FOR CORRECTIONS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 90004

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2000 E. Madison St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Paulina Gibbert

(a) Residence No..... 2000 E. Madison St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Gibbert

6-DATE OF BIRTH (month, day and year) May 15th 1844

7-AGE. 80 yrs. 3 mos. 19 ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Leonard Nussenkaber

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Lottie Meisenkaber

(Address) 2000 E. Madison St

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

SEP 5 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). September 4/24

17- I HEREBY CERTIFY, That I attended deceased from January, 1918, to September 3, 1924

that I last saw h.. alive on September 3, 1924

and that death occurred, on the date stated above, at 8.A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

Sept 5, 1924 (Address) 2005 E Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL, Sept 8, 1924

20-UNDERTAKER. J. J. Wenderow ADDRESS 156 Eutaw

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 90005 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 90005

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ignatius Ahern

(a) RESIDENCE NO. Old Soldiers Home ST. Pikesville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Maria Ahern

6 DATE OF BIRTH (month, day, and year) April 4 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate agent

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John Ahern

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Slater

13 BIRTHPLACE OF MOTHER (city or town) Frederick Md

(State or country)

14 Informant Frank I. Ahern Jr

(Address) Camp Alfred Vail N. J.

15 Filed ....., 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/24

17

I HEREBY CERTIFY, That I attended deceased from 8/30/24, 19....., to 9/4/24, 19, that I last saw him alive on 9/4/24, 19, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis.

(duration) ..., yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Hellery M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	Sept 6 1924

20 UNDERTAKER Chas. E. Black ADDRESS 742 W. Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EP5 - 1924

Cor.—1-12-23—M&T—100 Bks.

(Foltin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90006

CERTIFICATE OF DEATH.

74-001

D 90006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2060 W. 39th ST. (13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Foltin

(a) RESIDENCE NO. 2060 W. 39th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Foltin

6 DATE OF BIRTH (month, day, and year) April 2-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62.	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country) Harford

PARENTS

10 NAME OF FATHER Robert Foltin

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Esther Briley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Foltin
(Address) 2060 W. 39th St.

15 Filed SEP 5 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Monroe, M. D.
(Coroner.)

Sept 4, 1924. (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 6 1924

20 UNDERTAKER Chenoweth & Son — ADDRESS 3617 Chestnut Ave

G.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90007

CERTIFICATE OF DEATH.

23

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 Light St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H Reed

(a) Residence No. 714 Light St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Reed

6-DATE OF BIRTH (month, day and year) Jan 29 1866

7-AGE. 58 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Gaither Bldg

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George W Reed

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Mrs Charlotte S. Reed

(Address) 714 Light St

15- 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 3/24

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1924 to Sept. 3, 1924

that I last saw him alive on Sept. 3, 1924

and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Duration) 1 yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? I dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physicalagus

Sept 4 1924. (Signed) J. Edward Norris M. D.

(Address) 107 E Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	Sept 6, 1924
20-UNDERTAKER. John F Denny	ADDRESS. 715 Light St

EP 5

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90008

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-08 90008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 614 S Streeper St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary A. Ratkin

(a) Residence No. 614 So. Streeper St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 3 1924

7-AGE, ...yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER Herman C Ratkin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Agnes Schmittel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Agnes Schmittel

(Address) 614 S. Streeper st.

15- Filed SEP 5 - 1924 Robert P. Watkins Registrar.

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1924, to....., 19.....

that I last saw h.. alive on Sept. 4, 1924

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) L C Schlichal M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cemetery — DATE OF BURIAL, Sept 7, 1924

20-UNDERTAKER Scott J Turner — ADDRESS 1442 N Broadway

5a—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-2[illegible]-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90009

CERTIFICATE OF DEATH.

D 90009

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Kaetzle

(a) Residence No. 73- Cuthbert Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? LIFE yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Oct. 1-1923

7-AGE. ..... yrs. 11 mos. 3 ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, John O. Kaetzle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Mary H. Yeager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14- (Informant) John Kaetzle

(Address) 73- Cuthbert Ave

15- Filed 1924, 192..... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 4/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2 19 24 to Sept. 4 19 24

that I last saw her alive on Sept 4 19 24

and that death occurred, on the date stated above, at 10 30 M. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ——

Was there an autopsy? No.

What test confirmed diagnosis? Culture +

(Signed) J. C. Bowers M. D

19 (Address) 904 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem — DATE OF BURIAL. 9/6 19 24

20-UNDERTAKER. George J Ruth per A Hilts — ADDRESS 1735 Harford Ave

EP5

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90010

CERTIFICATE OF DEATH.

8 44

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nonnie Brown

(a) Residence No. 1632 St. Joseph St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE. 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Virginia
(State or Country).

PARENTS.

10-NAME OF FATHER, Ned Chaffin

11-BIRTHPLACE OF FATHER (city or town) Va.
(State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Va
(State or Country).

14- (Informant) Municipal Hospital Records

(Address) .....

15- Filed SEP 6 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-1-24

17- I HEREBY CERTIFY, That I attended deceased from 8-30, 1924 to 9-1, 1924

that I last saw him alive on 9-1, 1924

and that death occurred, on the date stated above, at 10^45 p. m.

The CAUSE OF DEATH* was as follows:

Malignancy (?)
Secondary Anemia

(Duration) ..... yrs. 4 mos. (history) ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude B. Drane M. D.

9-3, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Lynwood Gdns	Sept 6, 1924
20-UNDERTAKER	ADDRESS
Wm H Chase & Son	1400 Mosher

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9001 E

CERTIFICATE OF DEATH.

112

D 9001 E

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Vincent ST.: 16 WARD)

2-FULL NAME John Thomas Pinder

(a) RESIDENCE. No. 1104 Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 28-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Rachael Pinder

13 BIRTHPLACE OF MOTHER (city or town) City.
(State or country)

14 Informant
(Address) Jennie Tucker

15 Filed SEP 6 - 1924, 19

Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924, to Sept. 4, 1924, that I last saw him alive on Sept. 3, 1924, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Spasms 12 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute gastritis
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) John H. Timmins M. D.

(Address) 1914 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawn — DATE OF BURIAL Sept 6 1924

20 UNDERTAKER Chas W Chase & Son — ADDRESS 1400 Mosher

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 90912

Registered No.

1-PLACE OF DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Asylum St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Tuttle

(a) Residence No. 204 West Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, white.

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864.

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborman. (Odd).

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

166

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Hospital Records.

(Address) Bay View Hospital.

15- 192 Robert P. Harrison, Registrar.

SEP6-1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-5-24

17- I HEREBY CERTIFY, That I attended deceased from 2-16- 19 24 to 9-5- 1924 that I last saw h. alive on 9-5- 1924 and that death occurred, on the date stated above, at 2.55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Carcinoma Roof of the Mouth

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? 204 W Fayette St.

Did an operation precede death? yes Date of 5/7/24.

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Lab. tests.

(Signed) Dr. P. Chaney - Md M. D.

Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL, Sept 7, 1924

20-UNDERTAKER. J. Ahrens & Co — ADDRESS 1611 Madison Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS I... of in... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See instructions on back of certificates. OCCUPA...

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90013 D 90013

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Walden Circle ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J Morgan Snowden

(a) RESIDENCE NO. 1302 Walden Circle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Alice G Snowden

6 DATE OF BIRTH (month, day, and year) Jan 26-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Thomas A Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Ellen L Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant (Address) Alice G Snowden 1302 Walden Circle

15 Robert F. ... .19 ... Registrar

Burial Permit Clerk.

SEP 6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1923, to Sep 4, 1924, that I last saw him alive on Sep 4, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of November 1923

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) J P Swan M. D.

Sep 5 1924 (Address) 865 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Mays Hampden DATE OF BURIAL Sept 6 1924

20 UNDERTAKER D S Marshall ADDRESS 3539 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 D 90014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 730 N. Carolina ST., 10 WARD)

2-FULL NAME Virginia Proctor

(a) RESIDENCE NO. 730 N. Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14 yrs ~~1910~~	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Wm Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Annie Proctor
(Address) 730 N. Carolina St

15 Filed SEP 6 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) √ Sept 1924

17

I HEREBY CERTIFY, That I attended deceased from 3 Sept. 1924, to √ Sept. 1924.

that I last saw h[illegible] alive on √ Sept. 1924,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis.

about √
(duration) — yrs. — mos ^ ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Home

(Signed) C. Mayfield Boyle, M. D.

1 Sept 24 (Address) 1426 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sep 6 1924

20 UNDERTAKER Mrs R C Elliott ADDRESS 720 Eastland

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Foulkes)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90915

CERTIFICATE OF DEATH.

101-001

D 90915

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 679 Vine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Foulkes

(a) RESIDENCE NO. 679 Vine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4ye yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	1900	Oct	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass & Copper Wo

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Balto Copper Works

9 BIRTHPLACE (city or town) (State or country) Crew Va.

PARENTS

10 NAME OF FATHER Simon Foulkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crew Va

12 MAIDEN NAME OF MOTHER Fanny Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Foulkes (Address) 679 Vine Street

15 Filed SEP 6 - 1924 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1924

17 I HEREBY CERTIFY That I attended deceased from Aug 26, 1924, to Sep 5, 1924, that I last saw him alive on Sep 4, 1924, and that death occurred, on the date stated above, at 1225 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symp

(Signed) R R Tenyon, M. D.

Dr/5 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Potters Field	Sept 6 19
20 UNDERTAKER	ADDRESS
Mrs R G Elliott	1725 Ashland Av

Cor.—1-12-23—M&T—100 Bks.

D 90016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90016

CERTIFICATE OF DEATH.

M/H -001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1704 Ellamont ST., 15 WARD)

2-FULL NAME LeElla McLaughlin Diggs

(a) RESIDENCE No. 1704 Ellamont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Frank Diggs

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hair Dresser
(b) General nature of industry, business, or establishment in which employed (or employer) 886
(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Tapman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. J. Frank Diggs
(Address) 1704 Ellamont St.

15 Filed SEP 6 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner, aforesaid, inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage, 4 ds.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Sept. 5, 1924 (Address) 2 802 Cathedral Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemet	Sept. 8 1924
20 UNDERTAKER Wm Tuckwell Sons	ADDRESS North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90017

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 N. Dallas St St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Rain

(a) Residence No. 1301 N. Dallas St St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) Feb 17 1864

7-AGE. 60 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), France

PARENTS.

10-NAME OF FATHER, Karl Fishbeck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country).

14- (Informant) Margaret Lentz

(Address) 721 W. Lafayette Ave

15- Filed ..... 192.....

Robert F. [illegible] Registrar.

Burial Permit [illegible]

SEP6 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 4 1924

17- I HEREBY CERTIFY, That I attended deceased from May 17— 1924 to Sept. 4— 1924, that I last saw her alive on August 27— 1924, and that death occurred, on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Heart disease - Aortic Valves

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Edwin B. Fenby, M. D

9/5/1924 Address 1223 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Sept 8, 1924
20-UNDERTAKER.	ADDRESS
Frank A. Fink	9150 Gough

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90018 D 90018

CERTIFICATE OF DEATH.

212

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 76 WARD)

FULL NAME Charles V. Holman.

(a) RESIDENCE NO. 3521 E. Fairmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, HUSBAND of (or WIFE of) Mary F. Holman.

6 DATE OF BIRTH (month, day, and year) February 26, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pugilist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Victor Holman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lula Van Pelt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Mary F. Holman. (wife)
(Address) 3521 E. Fairmount Ave.

15 Filed SEP 6 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage.
caused during a pugilistic contest.
Accidental Death.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Sept. 5, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Holly Theatre, September 3, 1924.

Former or usual residence

19 PLACE OF BURIAL CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Sept 6, 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E. Hoffman

(GINK—THIS IS A PER... CAUSE OF DEATH should be stated ... AGE should be stated ... that it may be properly clas... TION is very important. See instructions on back of certificate.

D 90019 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 90019

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 35 S Bond ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walker Rain

(a) RESIDENCE NO 35 S. Bond ST., 3d WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Rain

6 DATE OF BIRTH (month, day, and year) Dec 26 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 140
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Kennedy

9 BIRTHPLACE (city or town) (State or country) Gilbert Hollow South Carolina

PARENTS

10 NAME OF FATHER James Rain

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Amanda Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Letha Gates

(Address) 1439 Fallsway

EP6 Filed 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Embracemia

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) De Compensation

(duration) ..... yrs. 4 mos. ..... ds.

(Signed) James M Kuhlen, M. D. (Coroner)

Sept 6, 1924 (Address) 701 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BUR
Asbury Cemetery	Sept 6
20 UNDERTAKER	ADDR
Milton Davis 315 N E	

AGE should be stated EXACTLY. PHYSICIAN should be careful. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP6 - 1924

Spec. 1-10-21 M&T 1500 Blks.

D 90020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 Ridgewood - Rd. 27 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frederick Schoenherr.

(a) RESIDENCE No. 101 Ridgewood Ave., Roland Park WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian A. Woodward

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	49	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer 645

(b) General nature of industry, business, or establishment in which employed (or employer) Lapsley-Interstate

(c) Name of employer Shade Cloth Co.

9 BIRTHPLACE (city or town) Hoboken
(State or country) N. J.

PARENTS

10 NAME OF FATHER Frederick Schoenherr

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Meyersfeld

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant L. W. Wolf
(Address) 1143 Garden St. Hoboken, N. J.

15 Filed ..... 19 ..... Robert P. Harrison,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to Sept 3, 1924;

that I last saw him alive on Sept. 3, 1924;

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? - Place of death.

Did an operation precede death? Yes Date of March 27/1924

Was there an autopsy? No.

What test confirmed diagnosis? Pathological Section -

(Signed) Joseph William Kelley, M. D.

(Address) 910 Brooks - Lane -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL 9/6 1924

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90021

CERTIFICATE OF DEATH.

D 90021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Haubert St., St. 24 Ward)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Hansel.

(a) RESIDENCE NO. 1303 Haubert St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 2, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	---	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard Hansel.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Cumberland Md.

12 MAIDEN NAME OF MOTHER Mary Heilbauer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria.

14 Informant Mary B. Hansel. (mother)
(Address) 1303 Haubert St.

15 Filed SEP 6 - 1924 192 Registrar.

Daniel Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 5, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. ... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 5, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. & C. Co.	Sept 6 1924
20 UNDERTAKER	ADDRESS
Chas. L. Stevens	1501 E Fort Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 99022 D 99022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 313 Gusewood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Andrew Beck

(a) Residence No. 313 Gusewood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah Emma

6-DATE OF BIRTH (month, day and year) Aug 10 1857

7-AGE 66 (69) Yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. R.R.

9-BIRTHPLACE (city or town) (State or Country). Penn

PARENTS.

10-NAME OF FATHER, Henry Beck

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penn

12-MAIDEN NAME OF MOTHER, Louisa Hamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Penn

14- (Informant) Gertrude L. McClelland

(Address) Hamilton Md.

15- Filed SEP 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 5 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 24 to Sept 5 24

that I last saw h.. alive on Sept 5 24

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Saunders M. D

, 19 (Address) 219 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lamb's Run Park DATE OF BURIAL. Sept 5, 1924

20-UNDERTAKER. Wm Corbin ADDRESS 504 E. Pratt

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90023

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Gilmor ST. 16 WARD)

2-FULL NAME Samuel Handy

(a) RESIDENCE. No. 811 N. Gilmor ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Handy

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Owen Daily

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Nancy Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Handy
(Address) 811 Gilmor St

15 Filed SEP 6 - 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 4 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 29th, 1924, to Sept 4th, 1924, that I last saw h[illegible] alive on Sept 4th, 1924, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 811 N. Gilmor St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine examination

(Signed) Jas C Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Queenstown Md	Sept 7 1924
20 UNDERTAKER	ADDRESS
Samuel Wemsley	Wilde

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90024

HEALTH DEPARTMENT—CITY OF BALTIMORE

90024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2321 E. Preston St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emelia Huether

(a) Residence No. 2321 E. Preston St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Huether

6-DATE OF BIRTH (month, day and year) March 4 1863

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Germany

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louis Huether
(Address) 2321 E. Preston St.

15- Filed Sept 8 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

SEP 8 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 4-1924

17. I HEREBY CERTIFY, That I attended deceased from August 26 1924 to Sept. 4 1924

That I last saw her alive on Sept 4 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) A. P. Herzog M.D. M. D.

Sept 5. 1924 (Address) 1305 N. Patterson Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cemetery	Sept 8 1924
20-UNDERTAKER.	ADDRESS
Forrest [illegible]	1600 W North Ave

N B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90025

CERTIFICATE OF DEATH.

38

D 90025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 W. Preston ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Simonds

(a) RESIDENCE NO. 321 W. Preston ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stable Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Blanche Skinner
(Address) 321 W Preston St

15 Filed SEP 6 - 1924 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Sept. 5, 1924 (Address) 280 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Sept 7 1924
20 UNDERTAKER Samuel Hensley	ADDRESS 1132 E Baltimore

N. B.—WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90026

D 90026

CERTIFICATE OF DEATH.

185

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

2-FULL NAME Mrs Cora E. L. Copping

(a) RESIDENCE No. 123 W 22nd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Rev. Bernard Copping

6 DATE OF BIRTH (month, day, and year) Feb. 9-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) Brewer
(State or country) Maine.

PARENTS

10 NAME OF FATHER Jeremiah Lyons.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maine.

12 MAIDEN NAME OF MOTHER Betsy Gordon

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maine.

14 Informant Betsy L. b. Copping
(Address) 212 Ridgewood Rd.

15 Filed SEP 6 - 1924, 19 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/1/24, 19.24., to 9/5/24, 1924, that I last saw her alive on 9/5, 1924, and that death occurred, on the date stated above, at 3:15A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

O.K. coroner F.J. Morrissey

(duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (Secondary) Fracture of femur

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical evidence

(Signed) Clewell Howell, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brewer Maine	9/8/24
20 UNDERTAKER	ADDRESS
A E Hughes 4247	Broadway

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90027

CERTIFICATE OF DEATH.

X 71-002

1-PLACE OF DEATH St Jos Hospital

Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Blevins

(a) Residence No. Rocks Md St.,.....Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F Blevins

6-DATE OF BIRTH (month, day and year) Unknown 1877

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) Crumpler (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Robert Gambill

11-BIRTHPLACE OF FATHER (city or town) Crumpler (State or Country), N.C.

12-MAIDEN NAME OF MOTHER, Nancy Jones

13-BIRTHPLACE OF MOTHER (city or town) Crumpler (State or Country), N.C.

14- (Informant) Cyrus C Blevins

(Address) Rocks Md

15- Filed SEP 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6th 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1924 to Sept 6th 1924

that I last saw her alive on Sept 6th 1924

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart, secondary to a cerebro-spinal meningitis the type of which is unknown (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebro-spinal meningitis (Duration) yrs. mos. 2 ds.

18-Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. B. Seybert M. D.

, 19 (Address) St Jos. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Jarrettsville Md

DATE OF BURIAL, ..., 19....

20-UNDERTAKER. E Stirtz & son

ADDRESS Jarrettsville Md

NOW B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 90028

CERTIFICATE OF DEATH.

46 B 90028

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 Wansley ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie West

(a) RESIDENCE NO. 428 Wansley St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12, 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Morgan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant H. M. Baker

(Address) 827 Hamilton Ter.

15 Filed SEP 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1922, to Sept 4, 1924, that I last saw h.. alive on Sept 4, 1924, and that death occurred, on the date stated above, at 11 30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and General peritonitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo. L. Hall, M. D.

, 19 (Address) 426 E. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sewell, Md. DATE OF BURIAL Sept 7 1924

20 UNDERTAKER H. K. McComas ADDRESS Lexington

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90029

CERTIFICATE OF DEATH.

D 90029

Registered No.....

1-PLACE OF DEATH Municipal Hospital Hart H. 46

City of BALTIMORE: (No. Bay View Hospital St., Ward 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levinia Lee.

(a) Residence No. 1502 Brunt Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. How long in U. S., if of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1868.

7-AGE. 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

037

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James Curry.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Lizzie Campbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant)..... (Address) Hospital Records B.V.H.

15- Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

SEP 7 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-4-24

17- I HEREBY CERTIFY, That I attended deceased from 6-13-24, 19.. to 9-4-24 19.., that I last saw her alive on 9-4-24 19.., and that death occurred, on the date stated above, at 10.55 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

General Metastases.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory Evs.

(Signed) Wm. P. Champe. M.D., M. D.

Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19..
Lancaster Va	9/7/24
20-UNDERTAKER. Daniel Carter	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90030

CERTIFICATE OF DEATH.

7A-001 D 90030

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Allendale Road ST., WARD 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia L Webb

(a) RESIDENCE NO. 2303 Allendale Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? 83 yrs. 11 mos. 5 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nathaniel H. Webb

6 DATE OF BIRTH (month, day, and year) Aug 5 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	83	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto City Md (State or country)

PARENTS

10 NAME OF FATHER Wm H. Kennard

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Spies

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Addie Cooper - Sister (Address) 2303 Allendale Road

15 Filed. SEP 7 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Sept 5, 1924, that I last saw h[illegible] alive on Sept 4, 1924, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - cerebral hemorrhage & paralysis

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) High blood pressure + arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S Culbreth, M. D.

Sept 6, 1924 (Address) 2220 Harlem ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauden Park Cemetery — DATE OF BURIAL Sept 8th 1924

20 UNDERTAKER C. Carson Kennard — ADDRESS 733 W Lafayette Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

174312

D 90031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D 90031

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE No. Ellicott City. 49. Fr. 3 ST., WARD

(Usual place of abode) Maryland

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sadia Smith

6 DATE OF BIRTH (month, day, and year) [illegible] 188[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	[illegible]	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Aromac. Co (State or country) Virginia

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Becky Bivens

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14

Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15

Filed SEPT - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug 26th, 1924, to Sept 5th, 1924,

that I last saw him alive on Sept 5th, 1924,

and that death occurred, on the date stated above, at 530 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Hypertension

Chronic nephritis

Myocardial failure

(duration) ..... yrs. 2½ mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia - Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen M. D.

Sept 5, 1924 (Address) Johns Hopkins Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leland Cemetery	Sept 8th 1924
20 UNDERTAKER [illegible]	ADDRESS [illegible]

Spec.—1-10-21—M&T 1500 Bks.

D 90032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90032

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Levine

(a) RESIDENCE NO. 916 Whiteleock ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Levine

6 DATE OF BIRTH (month, day, and year) Lithuania

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 888

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Levine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Linton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis 1439 Eutaw Pl.

(Address)

Filed SEP 7 - 1924 ROBERT R. KRAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Sept 7, 1924, that I last saw h.. alive on Sept 7, 1924, and that death occurred, on the date stated above, at 2 45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Chronic Nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ..... yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Questionable

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General physical Ex.

(Signed) M. Sherry, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrendash Road

DATE OF BURIAL 9/7 1924

20 UNDERTAKER Jack Levis 1439 Eutaw

ADDRESS Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174467 90033

32 D 90033

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Hale

(a) RESIDENCE NO. Tudor Hall University Parkway

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 4, 1921

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Dean Hale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Natalie McKeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEPT - 1924 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1924, to Sept 5, 1924, that I last saw her alive on Sept 5, 1924, and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Aug Jacobsen M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Ridgely

DATE OF BURIAL: Sept 8 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Supervisor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21 M&T 1500 Bks.

Livezey

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 90034

CERTIFICATE OF DEATH. X 129

D 90034

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2732 N. Calvert ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvania S. Livezey.

(a) RESIDENCE NO. Bel Air, Md., R. F. D. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred residing yrs. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Thomas N. Livezey Jr.

6 DATE OF BIRTH (month, day, and year) March 14 [illegible], 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	75	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home. ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER Catharine Kessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila., Pa.

14 Informant J. L. Nagle

(Address) 2222 Pylesgrove St., Balto. Md.

15 Filed SEPT - 1924 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1924 ✓

17

I HEREBY CERTIFY, That I attended deceased from August 27, 1924, to Sept. 7th, 1924,

that I last saw her alive on Sept. 7th, 1924;

and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Neoplasm.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

Sept. 7 1924 (Address) 2000-80 Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Harford Co

DATE OF BURIAL Sept. 10 1924

20 UNDERTAKER Henry Fanning & Sons

ADDRESS Aberdeen Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 139 D 90035

REGISTERED NO.....

1-PLACE OF DEATH Maryland Neil Hosp.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara E. Dawson

(a) RESIDENCE No. Easton, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Dawson

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER James Trice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tedalsburg, Md.

12 MAIDEN NAME OF MOTHER Martha adkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant Mrs. Clara E. Dawson
(Address) Easton, Md.

15 Filed SEP 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924, to Sept. 7, 1924, that I last saw her alive on Sept 7, 1924, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

uterine fibroma

(duration) 15 yrs. estimated ds.

CONTRIBUTORY (Secondary) surgical shock

24 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept. 6, 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical and anatomical

(Signed) J. W. Augustine, M. D.

, 19 (Address) Mt Christopher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md.

DATE OF BURIAL 9/8/1924

20 UNDERTAKER W. W. Wilson

ADDRESS 1531 Maryland Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 90036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D 90036.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 22 114 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Ehlis Taylor

(Residence in Baltimore: No. 4113 Penhurst Avenue St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. September 8th (Month) (Day) 1920 (Year)

7-AGE.	If LESS than 1 day,
3 yrs. 11 mos. 28 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Harry W. Taylor

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Betty Ehlis

13-BIRTHPLACE OF MOTHER, (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. W. Taylor
(Address) 4113 Penhurst Avenue

15- Filed SEP 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th (Month) (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acidosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro-indigestion

(Duration) yrs. mos. ds.

(Signed) J. S. H. Cocke M. D.
(Coroner.)

9-6- 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Sept 8 1924

20-UNDERTAKER.	ADDRESS
Chas L. B. Cook	1003 N. Bond St.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90087.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 | 24

D 90037

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2533 Shirley Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Lewis W. Cadwallader

(a) Residence No. 2533 Shirley Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Cadwallader

6-DATE OF BIRTH (month, day and year): Nov. 6th 1836

7-AGE: 87 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Police Captain

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto City

9-BIRTHPLACE (city or town): Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER: Abel Cadwallader

11-BIRTHPLACE OF FATHER (city or town): Phila (State or Country), Pa.

12-MAIDEN NAME OF MOTHER: Mary A. Gill

13-BIRTHPLACE OF MOTHER (city or town): Govans (State or Country), Md.

14- (Informant): Mrs. Josephine Loveland

(Address): 2533 Shirley Ave.

15- Filed SEP 6 - 1924 ROBERT R. KRAUTER Registrar. Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 6 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1st 19 24 to Sept 6th 19 24

that I last saw him alive on Sept 6th 19 24

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

Chronic Interstitial Nephritis

(Duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Uraemia

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 1/24

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Reuben F. Kellerman, M. D.

19 (Address) 6 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Sept 9 1924

20-UNDERTAKER: Louis B. Cook — ADDRESS: 1003 N. Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90038 (1) 129 D 90038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 8 WARD)

2-FULL NAME Roy A. Kingsbury

(a) RESIDENCE NO. 1944 N. Pattterson Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1909

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
15	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur W. Kingsbury

11 BIRTHPLACE OF FATHER (city or town) Montandon (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary E. Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Mercersburg (State or country) Pennsylvania

14 Informant Mother (Address) Mercy Hospital, Calvert St.

15 Filed ..... 19 ROBERT N. KRAUTER, Burial Permit Clerk Registrar

SEP 10 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/24

17

I HEREBY CERTIFY, That I attended deceased from 8/22/24, 19..., to 9/5/24, 19..., that I last saw h[illegible] alive on 9/5/24, 19..., and that death occurred, on the date stated above, at 6.45-0 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar
Pyloric Stenosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) R. W. Dolby, M. D.

9-6-24 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 8 1924
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 Druid

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90089

CERTIFICATE OF DEATH.

162 D 90039

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph McLaughlin

(Residence in Baltimore: No. 1119 N Gay St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	W	Single

6-DATE OF BIRTH, 9 (Month) 2 (Day), 1914 (Year)

7-AGE, ...yrs. 5 mos. .....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph P. McLaughlin

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sadie Madden

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph P. McLaughlin

(Address) 1119 N. Gay St

15- SEP 8 - 1914 ROBERT R. KRAUTER,
Filed.....1914 101.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 7 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1914, to Sept 7 1914, that I saw h[illegible] alive on Sept 7 1914, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Colic

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) A. L. Hamstein M. D.

9/7, 1914. (Address) 733 Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Vincent's Cemetery	Sep. 8, 1914
20-UNDERTAKER	ADDRESS
Henry Houck & Son	1301 E Eager St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90040

CERTIFICATE OF DEATH.

3/ D 90040

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 14 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Robert J. Johnson

(a) Residence No. 1850 McHenry st. St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Johnson

6-DATE OF BIRTH (month, day and year) 1865? June 12

7-AGE.	If LESS than 1 day,
59 ? yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)..... 684

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Robert J. Johnson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Moore

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 8 1924 ROBERT A. KRAUSER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 25 1924 to Sept. 6 1924, that I last saw him alive on Sept. 6 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 14 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. F. White M. D.

9-6- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 9 1924
20-UNDERTAKER.	**ADDRESS**
Mr-Mrs A S Finch	1737 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90041

CERTIFICATE OF DEATH.

159-001 D 90041

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 S Fulton Ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Meiller

(a) RESIDENCE NO. 213 S Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1923

7 AGE: Years 1; Months 3; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Meiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Seith Meiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Frank J Meiller 213 S Fulton Ave

15 Filed ..... 19 ..... ROBERT S KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to Sept 6, 1924,

that I last saw h alive on Sept 6, 1924,

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. 5 mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) James R Brumbaugh M. D.

9/7, 1924 (Address) 1729 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 8 1924

20 UNDERTAKER: M. Mrch & S' Sons — ADDRESS: 1737 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90042

D 90042

CERTIFICATE OF DEATH.

75-001

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 S. Eutaw St. ST., 21 WARD)

2-FULL NAME Ella Wright. (C)

(a) RESIDENCE NO. 1234 S. Eutaw St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, widowed, or divorced XXXXXXXXXXXXX (or) WIFE of Thomas Wright. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	-----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10 NAME OF FATHER Thomas BRoyls (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Thomas Wright. (C) husband.
(Address) 1284 S. Eutaw St.

15 Filed ... 192... ROBERT S. KRAUSS Registrar

SEP 8 - 1924 Board Escutt Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 5, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Tumor.
Hemiplegia.
Acute dilatation of the Heart.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) one
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Feb. 6, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ont Auburn Cemetery

DATE OF BURIAL Sept 8 1924

20 UNDERTAKER R L Parham

ADDRESS 902 Leadenhall st

Spec.—1-10-21—M&T 1500 Bks.

John P. Lesniewski

D 90043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90043

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 268 S. Duncan ST., 7 WARD)

2-FULL NAME John P. Lesniewski

(a) RESIDENCE NO. 268 S. Duncan ST., 7 WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Antoni Lesniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Josephine Mikrota

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Josephine Lesniewski.
(Address) 268 S. Duncan St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1924, to Sept 7, 1924, that I last saw h.. alive on Sept. 7, 1924, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows: /

Pleuro Tuberculosis.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) " " " "

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Keller M. D.

(Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Sept 8 1924

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNEADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Medenick or Sydrych.

(a) Residence No. 162 Lancaster St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed 192

ROBERT N. KRAUSE, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from June 6 19 24 to Sept. 7 19 24 that I last saw him alive on Sept. 7 19 24 and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. findings

(Signed) J. F. White M. D.

, 19 (Address) M. T. H., Bay View

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus	Sept 10- 1924
20-UNDERTAKER.	ADDRESS
M. F. Sadowski	705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90045

CERTIFICATE OF DEATH.

3 1 ✓ D 90045

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 24 S. Carlton ST., (or) 18 WARD)

2-FULL NAME Sealon Maitland

(a) RESIDENCE NO. 24 S. Carlton ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susie Maitland

6 DATE OF BIRTH (month, day, and year) Feb 2, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	35	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Plymouth N. C

PARENTS

10 NAME OF FATHER Benjamin Maitland

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF ~~MOTHER~~ Fannie Moose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Benjamin Maitland
(Address) 24 S. Carlton St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1924 to Sep 5 1924

that I last saw him alive on Sep 5, 1924

and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) — yrs. 12 mos ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howell M.D.

19 1924 (Address) 119 N Carrollton Ave

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 8 1924

20 UNDERTAKER Sam'l W Goodlow — ADDRESS 1400 Madison

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

90046

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 90046

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) East Fort Ave & Atlantic Ave. ST., ... WARD) 16

2-FULL NAME ..... Ernest Taylor.

(a) RESIDENCE No. 419 N. Bond ST., ... WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 8 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) nov 20. 1911

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
13	8.	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER henry taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) va

12 MAIDEN NAME OF MOTHER brate reed

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) va

14 Informant cornelia taylor
(Address) 419 n. Bond st

15 Filed SEP 8 1924 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) As Fatal

(Duration) yrs. mos. ds.

(Signed) G E Gladden, M. D.
(Coroner.)
(Address) 423 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbutus cemetery
DATE OF BURIAL Sept 8 1924
20 UNDERTAKER Edward Bryson
ADDRESS 1631 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state mation, so that it may be properly classified. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90047.

CERTIFICATE OF DEATH.

74-001

D 90047

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Belt ST. 24 WARD)

2-FULL NAME Jacob Tweedale

(a) RESIDENCE. No. 1409 Belt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Tweedal

6 DATE OF BIRTH (month, day, and year) Aug 15th

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	79	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James Tweedal

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ellen Swann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Jacob Tweedale

(Address) 1409 Belt St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17

I HEREBY CERTIFY, That I attended deceased from 9.4.24, 19..., to 9.6.24, 19...,

that I last saw h in alive on 9.5.24, 19...,

and that death occurred, on the date stated above, at 12.48 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Previous Hemorrhage

(duration) yrs. 1 mos. ago ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Fowler M. D.

9.6. 19 24 (Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Evergreen~~ Cedar Hill	9/8/ 1924

20 UNDERTAKER ADDRESS

E J Fleming 1466 Battery ave

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90048

CERTIFICATE OF DEATH.

44

D 90048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 Taylor st ST., 9 WARD)

2-FULL NAME Walter. S. Rock.

(a) RESIDENCE NO. 2127 Taylor st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Rock.

6 DATE OF BIRTH (month, day, and year) Sept. 5/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Producer

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer 45

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Fredrick Rock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Sadie Rock

(Address) 2127 Taylor st

15 Filed Sept 8 1924 HUBERT F. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from January 1st, 1924, to September 5th, 1924, that I last saw h[illegible] alive on September 4th, 1924 and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 8 mos 4 ds.

CONTRIBUTORY (Secondary) Ephanolism

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination Analysis of stomach contents

(Signed) Geo. P. Edelby M. D.

1924 (Address) 522 E. Fayette st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept. 1924

20 UNDERTAKER George J. Rust

ADDRESS 1735 Harford ave.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 90049

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. Bouldin ST., 26 WARD)

2-FULL NAME Margaret Kandelhardt

(a) RESIDENCE No. 408 S. Bouldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman Kandelhardt

6 DATE OF BIRTH (month, day, and year) June 6 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Pfel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ..... Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman Kandelhardt
(Address) 408 S. Bouldin

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage of Stomach probably ulcer (duration) Sudden mos. ..... ds.

(Signed) James McPherson, M. D.
(Coroner.)

9/7/24, 1924 (Address) 101 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 9/9 1924

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90950 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90950

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

REGISTERED NO. 177

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Heck

(a) RESIDENCE NO. 418 N. Chester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav Wm. Heck

6 DATE OF BIRTH (month, day, and year) July 24/1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Anthony Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa

12 MAIDEN NAME OF MOTHER Marie Grocan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa

14 Informant (Address) Gustav Wm. Heck 418 N. Chester St

15 Filed [illegible], 192 RUBEN N. KRAUTZ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning-
Probably accidental
(Mistook mercury bottle for
headache powder bottle) Aug. 24/24 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Sept 7/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL 9/8 1924

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should study CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9005

CERTIFICATE OF DEATH.

X23 D 9005

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Community Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P Klee

(a) RESIDENCE NO. Gamber Md ST., WARD upper Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mall

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie C Klee

6 DATE OF BIRTH (month, day, and year): Nov 8

7 AGE — Years: 55 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Klee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Apitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Henry Klee

(Address): Westminster Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/7 1924

17

I HEREBY CERTIFY, That I attended deceased from 8/24, 1924, to 9/7, 1924.

that I last saw him alive on 9/7/24, 1924,

and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) 2 wks yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Decompression

Did an operation precede death? yes Date of 9/2/24

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — DATE OF BURIAL: Sept 9 1924

20 UNDERTAKER: W M Routson — ADDRESS: 230 N Greene

over

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90052

CERTIFICATE OF DEATH.

129 D 90052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4012 Edmondson Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Henry

(a) RESIDENCE NO. 4012 Edmondson ~~Ave~~ ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Trenton N. J.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Amy L. Ward

(Address) 4012 Edmondson

15 Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 4 1924, to Sept 17 1924, that I last saw h[illegible] alive on Sept 17 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Morbilli Hemitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) H. L. Kummer, M. D.

Sept 18 1924 (Address) 1924 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 18 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

SEP 23 1924 ROBERT R. REMAK Registrar

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

90053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90053

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Herr

(a) Residence No. 521 S. Curley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Herr

6-DATE OF BIRTH (month, day and year) 1865

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country),

PARENTS.

10-NAME OF FATHER, John Herr

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-6-24.

17- I HEREBY CERTIFY, That I attended deceased from 9-3, 1924 to 9-6, 1924 that I last saw him alive on 9-6, 1924 and that death occurred, on the date stated above, at 8-10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Dorsey, M. D.

9-6, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Sacred Heart.	Sept. 9, 1924
20-UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Luzerne Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90054 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90054

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 Forman ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Perry

(a) RESIDENCE NO. 1846 Forman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Perry

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
about	50	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co. Maryland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co. Maryland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary's Co Maryland

14 Informant (Address) John Perry 1846 Forman St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1924, to Sept 5 1924, that I last saw h[er] alive on Sept 5 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

not known duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical signs and symptoms

(Signed) John C. F. Campbell M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemtery

DATE OF BURIAL Sept 8 1924

20 UNDERTAKER Mrs Jas. H. Dennis per J. E. Nelson

ADDRESS 1303 Presstman St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90055 . HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 90 D. 90055

1-PLACE OF DEATH Cedarcroft

City of BALTIMORE: (No. 408 Hollen Road St., 27 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor V. Ortel

(a) Residence No. 408 Hollen Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Roland D. Ortel

6-DATE OF BIRTH (month, day and year) Sept 5-1890

7-AGE, 34 yrs. — mos. 2 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country), Balto. Md.

PARENTS:

10-NAME OF FATHER Harry Lawson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Margaret Blum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14- (Informant) Roland D. Ortel

(Address) 408 Hollen Road

15-

Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 7-1924

17- I HEREBY CERTIFY, That I attended deceased from April 20-24 to Sept 7 1924

that I last saw h[er] alive on Aug 27 1924

and that death occurred, on the date stated above, at 5.40a m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

preceded by an attack of acute nephritis

and followed by acute pulmonary edema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy, Myocarditis

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Emil Brach M. D

Sept 7, 1924 (Address) 570 S. 20th

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. Sept. 9-1924

20-UNDERTAKER, Chas F. Evans & Son — ADDRESS 1180 Mont & Royal Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90056

CERTIFICATE OF DEATH.

D 90056

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 2427 Lanvetta ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harris W. Helm

(a) Residence No. 2427 Lanvetta ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 9 mos. 1 ds How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Helen B. Helm

6-DATE OF BIRTH (month, day and year) Nov 29th 1879

7-AGE, 45 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Pool Shop 886

(b) General nature of industry, business, or establishment in which employed (or employer). Bar & Electric Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm E. Helm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Margaret Downs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs Helm W. Helm

(Address) 2427 Lanvetta ave

15- Filed ... 19... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924 to ~~Aug~~ Sept 5, 1924 that I last saw him alive on Sept 5, 1924 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy M. D.

Sept. 6, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakmont Cemetery	9/9/24, 19....

20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90057

D 90057

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 18 WARD)

2-FULL NAME William Downs

(a) RESIDENCE No. 950 W. Saratoga St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Jany 12/24

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lottie Downs
(Address) 950 W. Saratoga St

15 Filed ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gastro-intestinal indigestion

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collins, M. D.
(Coroner)

Sept 7/24 192 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? Hopkins
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	9.8.24 192
20 UNDERTAKER	ADDRESS
Daniel Easton per W. A. Williams	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 8 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90058

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Bay View Hospital St., T. B. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Lee

(a) Residence No. 703 or 707 Druid Hill Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 37 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1857.

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph Lee

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-

(Informant)

(Address) Records

15-

Filed ... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/6/24

17- I HEREBY CERTIFY, That I attended deceased from July 7 19 24 to Sept 6 19 24

that I last saw h[illegible] alive on Sept 6 19 24

and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

ancertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? uncertain

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Richard Schon, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 7 1924

20-UNDERTAKER	ADDRESS
J. W. Brown and Son	108 W. Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90059

CERTIFICATE OF DEATH.

151 D 90059

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. ..... Ward A. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Schultz

(a) Residence No. ..... Bay View asylum St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Edward Schultz

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-Informant Hospital Records

(Address) Bay View Hospital Ward A

15-Filed ..... 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-6-24

17- I HEREBY CERTIFY, That I attended deceased from 9-4-24 19..... to 9-6-24 19.....

that I last saw h.. alive on 9-6-24 19.....

and that death occurred, on the date stated above, at 12.00 Noon m.

The CAUSE OF DEATH* was as follows:

Senile gangrene of left foot and leg (inpected)

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory tests

(Signed) Fr. J. Champe M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	Sept 10, 1924
20-UNDERTAKER John F. Kenny	ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90060

CERTIFICATE OF DEATH.

133 D 90060

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1270 James St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K Parks

(a) Residence No. 1270 James St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Isaac H Parks

6-DATE OF BIRTH (month, day and year) Feb 3 1856

7-AGE. 68 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Fairmount Somerset Co Md

PARENTS.

10-NAME OF FATHER Henry Dorsey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Fairmount Somerset Co Md

12-MAIDEN NAME OF MOTHER Ann Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Fairmount Somerset Co Md

14- (Informant) Mrs Isaac H Parks

(Address) 1270 James St

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Muriel Perault Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6/1924

17- I HEREBY CERTIFY, That I attended deceased from May 25 1920 to Sept 6th 1924

that I last saw her alive on Sept 6th 1924

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Chr. cystitis & senility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. P. Harrison M. D.

9/7, 1924 (Address) 3328 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westover Somerset Co Md

DATE OF BURIAL. Sept 8 1924

20-UNDERTAKER. John F Denny.

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9006[illegible]

CERTIFICATE OF DEATH.

82 D 9006[illegible]

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 123 N Pearl St ST., WARD)

2-FULL NAME Rosa Cascio

(a) RESIDENCE No. 123 N Pearl St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of: Rosario Cascio

6 DATE OF BIRTH (month, day, and year): April 14th 1881

7 AGE: Years 42; Months; Days; If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cefalu

PARENTS

10 NAME OF FATHER: John Marsiglia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cefalu Italy

12 MAIDEN NAME OF MOTHER: Mary Marsiglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cefalu

14 Informant: Rosario Cascio

(Address): 123 N Pease St

15 Filed: Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 24, to Sept 6, 19 24, that I last saw h[illegible] alive on Sept 6, 19 24 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Kalustian M.D.

Sept 8, 19 24 (Address) 14 E. 50 Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Cathedral Cem. DATE OF BURIAL: Sept 10 19 24

20 UNDERTAKER: Geary & Jenkins & Son Co ADDRESS: Oakland & Mc Culloh Sts.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D 90062~~

CERTIFICATE OF DEATH.

49 D 90062

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33 & Calvert ST., 12 WARD)

2-FULL NAME Harry Lee Christopher

(a) RESIDENCE NO. 346 E. 28th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Ashton Christopher

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Oliver Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Ashton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Sarah H. Briggs

(Address) 1024 N Appleton St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6. 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 27. 1924. to Sept. 6. 1924.

that I last saw him alive on Sept 6. 1924

and that death occurred, on the date stated above, at 11 20 A m.

The CAUSE OF DEATH* was as follows:

Effect of the anesthetic on an extreme anemia.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Prolonged Bleeding Carcinoma of bladder (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? yes Date of Sept. 6. 1924.

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) Donald C. Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept 8 1924

20 UNDERTAKER Wm J Tuckwell Sons — ADDRESS Norfolk Va

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90063

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

113

D 90063

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1614 Aliceanna St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladyslaus Liszewski

(a) Residence No. 1614 Aliceanna St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 1 1924

7-AGE. yrs. 9 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Stanislaus. Liszewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Walerya Orzechowski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Mr Stanislaus. Liszewski

(Address) 1614 Aliceanna Street

15- Filed SEP 8 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sep 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924 to Sept 8, 1924

that I last saw h[illegible] alive on Sept 1, 1924,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(Duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kruger M. D

, 19 (Address) 2627 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Sep. 9 1924 19....

20-UNDERTAKER. John A. Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 90064

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital St.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecilia. Sabinska

(Residence in Baltimore: No. 418 S. Madeira Street St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, July 3, 1905
(Month) (Day) (Year)

7-AGE, 19 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machine Oporater
(b) General nature of industry, business, or establishment in which employed (or employer): Tack Factory

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph. Sabinski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna. Rutkowski

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Sabinski

(Address) 418 S. Madeira Street

15- Robert P. Harrison,

Filed ..... 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5/24, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Septicemia-incomplete abortion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

9/6/24 191... (Address) 508 E. North Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sep. 10. 1924

20-UNDERTAKER John M Weber

ADDRESS 1803 Bank

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90065

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 N. Stricker ST.; (WARD) 17

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rogers

(a) RESIDENCE. No. 304 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Rogers

6 DATE OF BIRTH (month, day, and year) Dec 25-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer- B.O.RR

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burlington N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Celia Rogers (Address) 304 N. Stricker St

15 Filed Sept 9 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7 1924 to Sept 6 1924 that I last saw h alive on Sept 6 1924 and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis (duration) yrs. 2 mos. ds. Chronic

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) H C Leach, M. D.

(Address) North Ave & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 9 th 1924

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90066

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4901 Crowson Ave. St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace M. Ryder

(a) Residence No. 4901 Crowson Ave. St., ... Ward, ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas H. Ryder

6-DATE OF BIRTH (month, day and year) June 13th. 1900

7-AGE. 24 yrs. 2 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS:

10-NAME OF FATHER. R. Lee Chambers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Sarah M. Padden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant) Chas H. Ryder

(Address) 4901 Crowson Avenue.

15-

Filed ..... 19.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 7, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Sept 7 1924

that I last saw h[illegible] alive on Sept 7 1924

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(Duration) 2 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) General Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Duncan M. D

Sept 8. 1924 (Address) 5106 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery. DATE OF BURIAL. Sept. 9 1924

20-UNDERTAKER. Chas F. Evans & Son ADDRESS 118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90067

CERTIFICATE OF DEATH.

46 D 90067

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Brunt ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Smith

(a) RESIDENCE NO. 1427 Brunt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Stephen Smith

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sarah A Smith

(Address) 1427 Brunt St

15 Filed ..., 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Sept 6, 1924.

That I last saw her alive on Sept 5, 1924,

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Wilbur Frey M. D.

9 E. 1924 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist Columbia

DATE OF BURIAL 9/9/24 19

20 UNDERTAKER David Forbes

ADDRESS 916 Pa ave

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90068

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Shell Road &34 Street St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Smialek

(a) Residence No. Shell Road & 34 Street St., Ward.

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH explicitly, WITH UNFADING INK—THIS IS IMPERATIVE. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH explicitly, in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): April 5 1924

7-AGE: ....yrs. 5 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Frank Smialek

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Mary Leczek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

11- (Informant): Mr. Frank Smialek

(Address): Shell Road & 34 Street

...ert J. Harrison,

Registrar.

...ermit clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 8 26

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2 19 24 to Sept 8 19 26

that I last saw h.e alive on Sept 8 19....

and that death occurred, on the date stated above, at 4 A.m.

The CAUSE OF DEATH* was as follows:

Ollis Colatis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Paralysis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Ryan M. D

(Address) 1515 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cem.	Sept. 9 1926

20-UNDERTAKER: John A. Weber ADDRESS 1803 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. DO NOT DETACH

Cor.—1-12-23—M&T—100 Bks.

D 90069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90069

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., WARD)

2-FULL NAME Anna M Crane

(a) RESIDENCE No. 2106 Barclay ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work clerk
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. F. & G. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. H. Crane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER E. Smythe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Herbert Crane
(Address) Lakewood N.J.

15 Filed ....., 192 Robert F. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)
....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millington Md DATE OF BURIAL Sept 9 1924

20 UNDERTAKER Harvey H. Loitz & Co ADDRESS 1531 W. Lombard St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90070

D 90070

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1621 Friendsberg ST., 12 WARD)

2-FULL NAME Grace Knight

(a) RESIDENCE NO. 1621 Friendsberg ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Reuben Knight

6 DATE OF BIRTH (month, day, and year): Jan 4 1862

7 AGE — Years: 62 — Months: 7 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Gallop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Hendrinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Reuben Knight
(Address) 1621 Friendsberg

15 Filed ..... , 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 2 , 1924 , to Sept 7 , 1924 ,

that I last saw h 4 alive on Sept 7 , 1924 ,

and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Fred C Jewett , M. D.

, 19 (Address) 2596 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 10 1924

20 UNDERTAKER: George L. Schmale — ADDRESS: [illegible]

SEP 13 1924

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90071 ✓ D 90071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 James ST.: WARD) 7

2-FULL NAME Gertrude Ellen Phillips

(a) RESIDENCE. No. 2213 James ST., WARD. 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 10-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Floyd. W. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Gertrude Eller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Floyd W Phillips

(Address) 2213 James St

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1926

17 I HEREBY CERTIFY, That I attended deceased from 8/18, 1926, to Sept 6, 1926 that I last saw h[illegible] alive on Sept 6, 1926 and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 2/ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ellen Henning, M. D.

9/7, 1926 (Address) 2007 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept. 10 1926
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 9 1926

WARNING—RESERVED FOR BANGS

NK—THIS IS A PERMANENT RECORD. Every ... of infor... GE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it ... at it may be properly classified. Exact statement of ... TION is very important. See instructions on ... s on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90072

D 90072

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH John Hopkins Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Clarence Ogden

(a) RESIDENCE NO. Fairmount - W. Va ST., WARD West Virginia

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White.	Widowed —

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs W.C. Ogden

6 DATE OF BIRTH (month, day, and year) Aug 4 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Ogden.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va —

12 MAIDEN NAME OF MOTHER Coombs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Record. Johns Hopkins Hosp.

(Address)

15 Filed ... 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17

I HEREBY CERTIFY, That I attended deceased from July 21 1924 to Sept. 8 1924.

that I last saw him alive on Sept. 8 1924,

and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:—

Pulmonary tuberculosis.

Myocardial insufficiency

Chronic nephritis —

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? West Va -

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Fred H. Allen M. D.

, 19 (Address) Johns Hopkins Hosp —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmount W.Va.	Sept 10 1924

20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter in file on Nov 6-1924 from Edward Novak)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90073

CERTIFICATE OF DEATH.

90 D 90073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital (St.) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Anthony

(a) RESIDENCE NO. 136 Carlton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 29 mos. 8 ds. 12

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25, 1844

7 AGE — Years: 79 — Months: 8 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Monroe Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Lucy Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Lucy Ferguson

(Address) 136 Carlton Street

15 Filed SEP 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 19 24

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 19 24, to Sept 6, 19 24, that I last saw him alive on Sept 6, 19 24, and that death occurred, on the date stated above, at 1:05 p.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Edward Novak, M. D.

19 (Address) 16 E. Pleasant St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cy

DATE OF BURIAL: Sept 9, 1924

20 UNDERTAKER: Leonard Whalin

ADDRESS 673 Saratoga St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90074

CERTIFICATE OF DEATH. 11-001 D 90074

REGISTERED NO. 16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Mosher ST., WARD)

2-FULL NAME Mrs. Morilla Matthews

(a) RESIDENCE NO. 1704 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Matthews

6 DATE OF BIRTH (month, day, and year): Aug. 2nd 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): King & Queen Co. Virginia

PARENTS

10 NAME OF FATHER: Thos. Trustan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sophronia Dunstall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): King & Queen Co. Virginia

14 Informant (Address): Mrs. Mary Lee 1704 Mosher St.

Filed SEP 9 - 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7th 19 24

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21st 19 24 to Sept 7th 19 24.

that I last saw h w alive on Sept. 7th 19 24

and that death occurred, on the date stated above, at 3:40 p. m.

The CAUSE OF DEATH* was as follows:

Influenza (Respiratory)

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) Jno E Bell M. D.

19 (Address) 1124 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 9th 19 24

20 UNDERTAKER: Clarence E Wagner — ADDRESS: 1364 Ka

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90075

HEALTH DEPARTMENT—CITY OF BALTIMORE

35-M D 90075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 620 S. Streeper St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Theodore Bernat.....

(a) Residence No. 620 S. Streeper St. St. ..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bernat

6-DATE OF BIRTH (month, day and year) October 18 1879.

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) for Standard Oil Co

(c) Name of employer..... Company

9-BIRTHPLACE (city or town). (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Peter Bernat

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Armenta Gomulka

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Poland

11- (Informant)..... Mary Bernat

(Address)..... 620 S. Streeper St.

15- ROBERT R. KRAUTER, Registrar.

SEP 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 6 1924.

17- I HEREBY CERTIFY, That I attended deceased from July 3 1924 to Sep 6 1924 that I last saw h.. alive on Sep 6 1924 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Lung

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... M. D

, 19 (Address) 301 Scharf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery	Sept. 9 1924.
20-UNDERTAKER.	ADDRESS
Kendall & Lippold Inc	3704 Keswick Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90076

CERTIFICATE OF DEATH.

44

D 90076

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 Granby St St., ... Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aloysia Kreeder

(a) Residence No. 1026 Granby St St., ... Ward .....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Kreeder

6-DATE OF BIRTH (month, day and year) June 19.

7-AGE. 58 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-DCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS:

10-NAME OF FATHER, Sebesta Wood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) John Kreeder

(Address) 1026 Granby St

15- SEP 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6 1924

17- I HEREBY CERTIFY, That I attended deceased from July 13 1924 to Sept 6 1924 that I last saw h— alive on Sept 6 1924 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Esophageal Carcinoma

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Geo. Hellar M D

9-7- 1924 (Address) 1937 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel DATE OF BURIAL 9/9/1924

20-UNDERTAKER Wendell & Appelman ADDRESS 37 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90077

CERTIFICATE OF DEATH.

49

D 90077

1-PLACE OF DEATH South Baltimore Gen. Hospl. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Katherine Mann.

(a) RESIDENCE No. 10 Belmar Ave ST. Raspeburg WARD 40

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 24th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER John W. Mann

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Steger

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant John W. Mann (Address) Raspeburg Md.

15 Filed Sept 9 24

SEP 9 - 1924

ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1924, to Sept. 8, 1924.

that I last saw her alive on Sept. 8, 1924

and that death occurred, on the date stated above, at 4:25 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Obstructive Jaundice

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Sept 4/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. E. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept. 10 24
20 UNDERTAKER	ADDRESS
Fredk Lissahm & Sons	Fulton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90078

90 D 90078

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital Eutaw Dr

CITY OF BALTIMORE, (No. Biddle St ST., WARD) 10

Sister Mo. Perpetua

2-FULL NAME Ellen Lorretta Early.

(a) RESIDENCE NO. Biddle St. ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? 29 yrs. 5 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 9 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cloaks & Skirts

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer Mussey Helpers Pittston Pa.

9 BIRTHPLACE (city or town) (State or country) Pittston Pa.

PARENTS

10 NAME OF FATHER Michael Early.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Honora O'Donnell 9/8

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Walter Rupprecht

(Address) Mussey Helpers.

Filed SEP 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 8 1923, to Sept 8 1924

that I last saw her alive on about Sept 8 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Embolism Cerebral Artery.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Dis. Chronic years.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. Hoffman Physician

(Signed) Dr. Hoffman, M. D.

(Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 9/9 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hartford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90079

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give NAME instead of street number and fill out No. 18.)

2-FULL NAME Minnie D Saunders

(a) RESIDENCE NO 612 W Barre St ST., ... WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3 1/2			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dorsey Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eva Dowdy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Allen Saunders (Address) 612 W Barre St

SEP9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

.....(duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Dont Know

.....(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Epstein, M. D.
(Coroner.)
Sept 9, 192 (Address) 1 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 10 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 102 Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90080

CERTIFICATE OF DEATH.

113

D 90080

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1765 Montpelier St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fletcher Kendall

(a) Residence No. 1765 Montpelier St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Aug 8 1923

7-AGE, 1 yrs. 0 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter C Kendall

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Dorothy Dryden

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country), ...

14-(Informant) Mr. Walter C. Kendall

(Address) 1765 Montpelier St

SEP 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 19 24 to Sept 6 19 24

that I last saw h. alive on Sept 6 19 24

and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

.....

.....

.....(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Defective type of Diet

Low Colon

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Smith M. D.

9/8/24 (Address) 4206 Harford

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cem. DATE OF BURIAL. Sept 1924

20-UNDERTAKER Wm Fletcher Sons ADDRESS Mortuary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7/4-001 D 90081

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 S Eden St. Ward) D

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... M. Theresa Gibson

(a) Residence No. 132 S Eden St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If ~~married~~, widowed, ~~or divorced~~, HUSBAND of (or) WIFE of John H Gibson

6-DATE OF BIRTH (month, day and year) July 15 1851

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) John B Gibson

(Address) 132 S Eden at

15- SEP 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 7 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924, to Sept 6, 1924, that I last saw her alive on Sept 6, 1924, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Saml Snyder, M. D.

(Address) 300 E Preston St Baltimore Eastern Disp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oak Lawn Cemetery	Sept 9, 1924
20-UNDERTAKER	ADDRESS
Robt J Turner & Co	1902 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90082

CERTIFICATE OF DEATH.

129

D 90082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Debes.

(a) RESIDENCE NO. 409 E St Paul St WARD 11

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 63 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joe Debes

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Elizabeth Mus[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Record

(Address) ...

15 Filed ... 19 ... ROBERT N. KRAUTER, Registrar

SEP 9 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8/24 19

17 I HEREBY CERTIFY, That I attended deceased from 8/22/24 19 ... to 9/8/24 19 ... that I last saw him alive on 9/8/24 19 ... and that death occurred, on the date stated above, at 5-00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept 10 19 24

UNDERTAKER Robt J Turner Sons

ADDRESS 410 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 90083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D 90083

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hosp.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cohen

(a) RESIDENCE NO. 506 E. Payson ST., ... WARD 20

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freda Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Russia

PARENTS

10 NAME OF FATHER Harris Cohen

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St.

15 Filed SEP 9 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1924, to Sept 8, 1924, that I last saw him alive on Sept 8, 1924, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Lethargica + Encephalitis

(duration) ..... yrs. ..... mos 2 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor Fine, M. D.

Sept. 9, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	9/9 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90084

CERTIFICATE OF DEATH.

D 90084

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2033 E. 32nd St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Adam George Snyder Sr.

(a) Residence No. 2033 E. 32nd St. St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret Snyder

6-DATE OF BIRTH (month, day and year) Sept. 17, 1863

7-AGE. 58 yrs. 11 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER. John Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. City

12-MAIDEN NAME OF MOTHER. Mary R. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. City

14-

(Informant) Margaret Snyder

(Address) 2033 E. 32nd St.

SEP 9 - 1924

Burial Permit Clerk.

ROBERT R. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 6/24

17- I HEREBY CERTIFY, That I attended deceased, from Aug. 31st 19 24 to Sept. 6 19 24

that I last saw him alive on Sept. 6 19 24

and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ... yrs. ... mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr. M. D.

9/8, 19 24 (Address) 2638 E. Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. Sept. 10th, 1924

20-UNDERTAKER. Philip Herwig ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90085

CERTIFICATE OF DEATH.

113 D 90085

1-PLACE OF DEATH

City of BALTIMORE: (No.) 703 S East Av St., 26 Ward) 6

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Szymanski

(a) Residence No. 703 S East Ave St., 26 Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 8 - 24

7-AGE. ..... yrs. 5 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Eduard Szymanski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Gastomska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) E. Szymanski

(Address) 703 S East Ave

15- SEP 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 8. 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 24 to Sept 8, 19 24

that I last saw him alive on Sept 8, 19 24

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Heller M. D.

9-9, 1924 (Address) 1937 Gough

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Sept 10, 1924
20-UNDERTAKER.	ADDRESS
F. W. Ozazenski	1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90086

CERTIFICATE OF DEATH.

X 155 D 90086

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Fairmount & Broadway St.) WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse H. Cook.

(a) RESIDENCE No. Franklin W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 Weeks yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27th. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John W. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Anna R Vandevender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant W. S. Dunkle

(Address) Circleville W. Va.

15 Filed SEP 9 - 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Sept 8, 1924, that I last saw him alive on Sept 8, 1924, and that death occurred, on the date stated above, at 6:58 P m.

The CAUSE OF DEATH* was as follows:

Nephritis
Uremia
Osteomyelitis of right leg

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 24 1924

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George B Brief, M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg W. Va.	9/9/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes,	424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90087 D 90087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 107 N. High St. ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella A. Foultz.

(a) RESIDENCE NO. 107 N. High St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, ~~widowed, or divorced~~ (or) WIFE of Charles W. Foultz.

6 DATE OF BIRTH (month, day, and year) February 17, 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	38	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Reading, Pa.

PARENTS

10 NAME OF FATHER Frank Bitters.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Ida M. Hoffman. (sister-in-law)
(Address) 107 N. High St

SEP 9 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Tumor.

Acute dilatation of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ....., M. D.

Sept. 8, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park — DATE OF BURIAL Sept 11 1924

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90088

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH ~~[illegible]~~ St Joseph's Hospital

City of BALTIMORE, (No. Rossville Balto Co Md St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Muldaur

(a) Residence No..... Rossville St., Baltimore County, Md Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Negro.

5-Single, Married, ~~Widowed,~~ or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Muldaur

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 55 yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore County

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Annie Myers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) George Muldaur

(Address) Rossville Baltimore Co Md

15-Filed SEP 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 4th 1924 (to Sept 6th 1924

that I last saw h.. alive on Sept 5th 1924

and that death occurred, on the date stated above, at 6 P M

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

9/6/1924 (Signed) Th Kirschner M. D.

(Address) St Josephs Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park Balto Co Md

DATE OF BURIAL, 9/9, 1924

20-UNDERTAKER. Samuel Hemsley

ADDRESS 578 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90089

CERTIFICATE OF DEATH.

D 90089

129

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. on Third Death Was found) ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Brown

(a) RESIDENCE No. 1019 N Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Col

PARENTS

10 NAME OF FATHER Joseph Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Agnes Williams 1019 Gilmor
(Address)

15 SEP 9 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 - 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 1 yrs. a few mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) W. R. Lyon, M. D.
(Coroner.)

9-9, 192 (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/9/ 1924
20 UNDERTAKER Samuel T. Hensley	ADDRESS 578 W Baltimore

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90090

D 90090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2632 Boone st. ST., WARD 21

2-FULL NAME Frank Henry Williams

(a) RESIDENCE No. 2632 Boone st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER August Spriggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank Williams

(Address) 2639 Boone st.

SEP 9 - 1924

Filed ROBERT A. KRAUTER, Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1924, to Sept. 8 1924.

that I last saw him alive on Sept. 8 1924,

and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Pulmonary Congestion with convulsion following Whooping Cough (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough & Bronchitis (duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Ted Hall, M. D.

, 19 (Address) 426 & 428 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 9 1924
20 UNDERTAKER	ADDRESS
J. Mac B. C. Elliott	1725 Ashland ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard of Dunbeck

(a) RESIDENCE NO. St Vincents Orphan Asylum WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924 March 15.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) ? Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hembeck.

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Magdalena Bengsberger

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7- 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 4 - , 1924, to Sept 7 - , 1924, that I last saw him alive on Sept 7 - , 1924, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and vomiting

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kemper M. D.

9/8, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery

DATE OF BURIAL Sept 9 1924

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OPERATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90092 CERTIFICATE OF DEATH.

38 D 90092

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Bowman

(a) Residence No. 819 W. Ostend St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James Bowman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address)

SEP 9 - 1924 ROBERT A. KRAUTER Registrar.

Burial Permit Clerk

1752

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-6-24

17- I HEREBY CERTIFY, That I attended deceased from 5-27 1924 to 9-6 1924

that I last saw him alive on 9-6 1924

and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Insufficiency, Myocardial Insufficiency

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Dixon M. D.

9-6 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

Commissioner Health. SEP 9 - 1924

UNIVERSITY OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90093 CERTIFICATE OF DEATH. 100-001 D 90093

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No..... St.,..... Ward) Municipal Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lino, Santiago ?

(a) Residence No. 600 Central ave & Exeter St., ... Ward. 12

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Black

5-(Single, Married, Widowed, or Divorced, (Write the word.) (Single)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 24 yrs. — mos. — ds.

If LESS than 1 day. ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sailor?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9-BIRTHPLACE (city or town) (State or Country), Livingston, Guatamala

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

11- (Informant).....

(Address).....

Filed SEP 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from 7/12/ 1924 to 9/7/ 1924 that I last saw h.m alive on 9/6/ 1924 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Alcoholic Psychosis.

(Duration) ....yrs. 2 mos. ....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no Fatty clinical findings.

What test confirmed diagnosis?

(Signed) A. J. Corbett M. D.

, 19 (Address) Bay View Asylum

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, | DATE OF BURIAL, ... 19....

20-UNDERTAKER. Commissioner Health, | ADDRESS

SEP 9 - 1924

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1753

Spec.—1-10-21—M&T—1500 Bks.

174399
D 90094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90094

CERTIFICATE OF DEATH.

16-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Dobbs

(a) RESIDENCE NO. 2032 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabella

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Warren Dobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sadie Merriken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 SEP9 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924, to Sept 8, 1924, that I last saw her alive on Sept. 8, 1924, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.

9/8, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 10 1924
20 UNDERTAKER	ADDRESS
Lounsbrook	502 E North.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90095

CERTIFICATE OF DEATH.

100-001 D 90095

REGISTERED NO.....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Goodman

(a) RESIDENCE NO. 1910 Eutaw Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Goodman

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mnfgr. Ladies

(b) General nature of industry, business, or establishment in which employed (or employer) to wear

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Simon Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Gutman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Laurence Goodman

(Address) Nashville, Tenn.

15 Filed SEP 9 - 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1924, to Sept. 8, 1924, that I last saw h[illegible] alive on Sept. 8, 1924, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Chr. bronchitis; bronchopneumonia

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidore S. Levy, M. D.

Sept. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 9/10/1924

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

90096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90096

CERTIFICATE OF DEATH.

129

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Laurens St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winnie Nunnelley

(a) RESIDENCE. No. 515 Laurens St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 25-1845

7 AGE: 78 Years 9 Months 23 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Evert Jones

(Address): 515 Laurens St

SEP 9 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/8 19 24

17

I HEREBY CERTIFY, That I attended deceased from 7/4 19 24, to 9/8 19 24,

that I last saw h... alive on 9/8 19 24,

and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

(a) Not Entered

(b) Nephritis & Uremia.

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj R. Leith, M. D.

9/9, 19 24 (Address) 219 D St. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va

DATE OF BURIAL: 9-9 1924

20 UNDERTAKER: George T. A. Gibson

ADDRESS: 1730 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90097 ✓ D 90097

CERTIFICATE OF DEATH.

9

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 110. N. Green St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. AGGIE UNITAS

(a) Residence No. 110. N. Green St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 19. 1924

7-AGE. ....yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... No
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)...Baltimore Md.....
(State or Country),

PARENTS.

10-NAME OF FATHER, J.J. Unitas

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Aggie Slger

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Lithvania

14-
(Informant)...J.J. Unitas.....
(Address)....110 N Green Street.....

15-
Filed.....19..... ROBERT R. KRAUTER, Registrar
SEP 9 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 9-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5th, 19 24 to Sept 8th, 19 24
that I last saw h. alive on Sept 8th 19 24
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.
9-9- , 1924 (Address) 510 N. Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Sept. 11 1924
20-UNDERTAKER.	ADDRESS
John A. Gieblinger	4253 Penn St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90098

CERTIFICATE OF DEATH.

90 D 90098

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 Franklin ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl C. Depew

(a) RESIDENCE NO. 1038 Franklin St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer Gompertz & Bearach Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad A. Depew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillie K. Herbold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lillie K. Depew (Address) 1038 W. Franklin st

15 Filed Sept 9 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1923, to Sept 7, 1924.

that I last saw him alive on Sept 7, 1924.

and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Chr. valvular disease

Chr. myocarditis

Chr. hemorrhagic nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pulm. edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis Laboratory test

(Signed) W. R. Lucas, M. D.

(Address) 3316 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 10 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90099 ✓

D 90099

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1018 Brentwood Ave St. Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Steinmeier

(a) Residence No. 1018 Brentwood Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23 1864

7-AGE. 59 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John Steinmeier

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER, Sophia N Hamilton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Frank Steinmeier

(Address) 1018 Brentwood Ave

15- Filed SEP 9 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). SEP 7 1924

17- I HEREBY CERTIFY, That I attended deceased from SEP 1 1924, 19....., to SEP 7 1924, 19.....

that I last saw h[illegible]M alive on SEP 7 1924, 19.....

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows: acute Dilated Heart

(Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. H. Duker M. D.

SEP 8, 1924 (Address) 928 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Sept. 10, 1924

20-UNDERTAKER, J. C. Wendfeld — ADDRESS 914 Greenmount Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90100

CERTIFICATE OF DEATH.

179 D 90100

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. A Drzybek

(a) RESIDENCE No. 701 S. Lakewood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) B C, Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER August Drzybek

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Marta Krupecky

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Wladek Drzybek
(Address) 701 S. Lakewood

15 Filed SEP 9 - 1924 192 Burial Permit Issued
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of Larynx & Congestion of Lungs

(duration) yrs. 1 mos. 44 ds.

CONTRIBUTORY (Secondary) Inhalation of gasoline & burns on face & hands (duration) yrs. mos. ds.

(Signed) W K Gorsel, M. D.
(Coroner.)

9-8, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Sept 11, 1924
20 UNDERTAKER	ADDRESS
M F. Sadowski	705 S. Ann

Robert P. Harrison,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 90101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4/3

D 90101

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 S. Wolfe ST., ... WARD) IV

2-FULL NAME Anna Miliewicz

(a) RESIDENCE NO. 922 S. Wolfe ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28-1923

7 AGE — Years: 1 — Months: 2 — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Miliewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Grace Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Peter Miliewicz (Address) 922 S. Wolfe St

15 Filed [illegible] 1924 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 7/2, 1924, to 9/8, 1924 that I last saw h[illegible] alive on 9/5, 1924 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia 2 w

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acc. Bronchitis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pottsburg Pa

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Straker, M. D.

, 19 24 (Address) 922 S Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn. DATE OF BURIAL Sept 10, 1924

20 UNDERTAKER W. J. Sadowski. ADDRESS 705 Ann St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D 90102

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hagan

(a) Residence No. 416 W. Saratoga St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE. 70 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Milliner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Edward Hagan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): do not know

12-MAIDEN NAME OF MOTHER: Ann Hagan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Do not know

14- (Informant) Miss Katherine Hagan
(Address) 416 W. Saratoga St.

15- Filed 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9/8/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1924, to 9/8, 1924, that I last saw her alive on 9/8, 1924, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Terminal bronchopneumonia
due to metastases from carcinoma
of the breast.
(Duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of the breast (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? 0

(Signed) John T. Sherman, M. D.
9/8, 1924 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: Sept 10" 1924

20-UNDERTAKER: Wm J Hartwell — ADDRESS 2236 W. Balto St

P9

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

179 19 90103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90103

1-PLACE OF DEATH

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Emma Morgan

(a) RESIDENCE No. 439 Orchard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Port Deposit, Md.

PARENTS

10 NAME OF FATHER: Paris Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Banfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 [illegible] Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 18 1924 to Sept 7 1924.

that I last saw her alive on Sept 7 1924

and that death occurred, on the date stated above, at 10-0 a m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculous pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen, M. D.

(Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Havre De Grace Md

DATE OF BURIAL 9/9/24

20 UNDERTAKER: David Easton

ADDRESS 916 Cc ave

SEP 9 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S blank should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90104

CERTIFICATE OF DEATH.

+73 D 90104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME David Meekins (David Z. Meekins)

(a) RESIDENCE No. University Hospital ST., WARD I Woodlawn, Maryland
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Meekins

6 DATE OF BIRTH (month, day, and year) Apr. 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Joshua Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Kesiah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Walter J. Crismer
(Address) Russell Ave. Broad Acres.

15 Filed 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/2 1924 to 9/7 1924, that I last saw h alive on 9/7 1924, and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Ascending myelitis - Hemorrhage in the Central Cord -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Woodlawn Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William S. Faal M. D.

9-8 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Balto Md — DATE OF BURIAL 9/10 1924

UNDERTAKER Joseph B Cook — ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and public officials CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90105

D 90105

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 Park Avenue-Wilhelm Park St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie E. Heckathorn

(a) Residence No.... 105 Park Ave.-Wilhelm Park St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Heckathorn Sr.

6-DATE OF BIRTH (month, day and year) May, 1853

7-AGE, ..71.. yrs. ..4.. mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Hudson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), United States

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Geo. E. Heckathorn

(Address) 105 Park Ave. Wilhelm Park

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Sept 6, 1924

that I last saw h.. alive on Sept 6, 1924

and that death occurred, on the date stated above, at 5.20 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) E. Hills Hemmeter M. D.

9-8-1924 (Address) 2000 Hollins Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Woodson Park Cem	Sept 10, 19 24
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90106

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90106

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellen J Zuckwick

(a) RESIDENCE NO. Families Anne Arundel Co Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adolph Zuckwick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 9 -1924, 19 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 30 1924, to Sept 8 1924, that I last saw him alive on Sept 8 1924, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and Vomiting

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Microcephaly

Life (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.

9/7, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem — DATE OF BURIAL Sept 10th 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90107

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Stein

(a) Residence No. 42 E. York st. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1904

7-AGE. 20 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Glass cutter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town), (State or Country), Washington, D. C.

PARENTS.

10-NAME OF FATHER, William Stein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington D. C.

12-MAIDEN NAME OF MOTHER, Hannah Selby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D. C.

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed SEP 9 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22 1924 to Sept. 7 1924

that I last saw h. im alive on Sept. 7 1924

and that death occurred, on the date stated above, at 10.30p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L. F. White M. D.

9-8- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. Loudon Park Cem. Sept. 11, 1924

UNDERTAKER. ADDRESS. Geo. L. Schwab 1101 Cook Ave.

IN B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90108

CERTIFICATE OF DEATH.

90

D 90108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Bond Alley ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elizabeth Dutton

(a) RESIDENCE NO. 826 Bond Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Henry Dutton

6 DATE OF BIRTH (month, day, and year): 11-14-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: J.W. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: Viola Mansell

(Address): 826 Bond alley

15 Filed SEP 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-7-1924

17 I HEREBY CERTIFY, That I attended deceased from 8/23, 1924, to 9/7, 1924, that I last saw her alive on 9/7, 1924, and that death occurred, on the date stated above, at 6:50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

Duration—yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Jackson, M. D.

9/7, 1924 (Address) 808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Sept 10 24
20 UNDERTAKER	ADDRESS
Samuel Handy	1738 Bolle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARRIAGE RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 90109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 001 D 90109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 644 Mosher ST., 14 WARD)

2-FULL NAME John H. Langley

(a) RESIDENCE NO. 644 Mosher ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Worked for hire

(b) General nature of industry, business, or establishment in which employed (or employer) Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER John Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Lenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed SEP 10 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4th, 1924, to Sept. 7th, 1924, that I last saw h.. alive on Sept. 6th, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Suspicion

(Signed) A. [illegible] Ellis, M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Sept 10 1924

20 UNDERTAKER [illegible] ADDRESS [illegible] Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90110

D 90110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital St., 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Craft

(a) RESIDENCE NO. — St., Ward Gallipolis Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Charles Craft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Alice White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Wm Curry
(Address) Bayview Hospital

15 Filed SEP 10 1924 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

probly Tubercular Meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) James McFerron, M. D. (Coroner)

Sept 9, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gallipolis Ohio	Sept 10 1924
20 UNDERTAKER	ADDRESS
Mc-Mrs N S Smith	1737 N Paca St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90111

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7414 Barclay St ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter A. Long

(a) RESIDENCE NO. 7414 Barclay St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May R. Long

6 DATE OF BIRTH (month, day, and year): Sept 17 1867

7 AGE — Years: 56 — Months: 11 — Days: 22 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer P.R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Richard D. Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Polly Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Mrs May R. Long 7414 Barclay St

15 Filed SEP 10 1924 19..... Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Sept 9, 1924,

that I last saw h[illegible] alive on Sept 8, 1924,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephr, Mitral Murmur

Dropsy

Hemorrhage

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis, Mitral Murmur

Hemorrhage (duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. B. Carman, M. D.

9-9, 19 24 (Address) 1702 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Sept 11 1924

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90112

Registered No.....

1-PLACE OF DEATH 112 N. Hare St

City of BALTIMORE: (No. 112 N. Hare St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Schilling

(a) Residence No. 112 N. Hare St., 6 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 8 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, Married, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Schilling

6-DATE OF BIRTH (month, day and year) Nov 28, 1840

7-AGE. 83 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Marcus Kaye

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) J. Chas. Schilling Jr.
(Address) 112 N. Hare St

15- Filed ..... 192.....
Registrar.

SEP 10 1924

ROBERT N. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924 to Sept 7, 1924 that I last saw her alive on Sept 7, 1924, and that death occurred, on the date stated above, at 7.35 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 31 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. ? mos. ....ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Visual Chemical

(Signed) C. C. MacDonald M. D.

1548 , 192 (Address) 1540 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cem	Sept. 10 1924
20-UNDERTAKER.	ADDRESS
Wm. E. Black	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1511 N. Mount St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) Residence No. 1511 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Negro	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6-DATE OF BIRTH (month, day and year) 9/5/24

7-AGE. 0 yrs. 0 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Charles M. Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Estelle Wilson.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Md.

14- (Informant) Charles M. Brown

(Address) 1511 Mount St

15- Filed SEP 10 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9-8-24.

17- I HEREBY CERTIFY, That I attended deceased from 9-5- 19 24 to 9-8 19 24

that I last saw h[illegible] alive on 9-8 19 24;

and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanna R. Evans M. D

9-x 19 24 (Address) 1702 West North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Sept 10 1924

20-UNDERTAKER: Mrs James H. Dennis — ADDRESS 1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90114 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1082 W. Kennedy ST. 22 WARD) 101-901

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Carter

(a) RESIDENCE. No. 108 W Kennedy ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of Certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced (Wife) HUSBAND of (Husband) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1854

7 AGE — Years: 70yrs — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte Md

PARENTS

10 NAME OF FATHER Charles Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Beatrix Robertson
(Address) 1082 W. Kennedy St.

15 Filed SEP 10 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Sept 8, 1924, that I last saw her alive on Sept 7, 1924, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. Lawrence D.

(Address) 7 E. 39 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Sept 11 1924

20 UNDERTAKER N. W. Brown & Son ADDRESS 1081 W. Mond'y

Spec.—1-10-21—M&T—1500 Bks.

Mozerowitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90115

D 90115

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mazerowitz

(a) RESIDENCE NO. 3446 Reisterstown ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sol Mazerowitz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55-69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Eddel Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Goldberg

(Address) 3524 Garrison

SEP 10 1924

Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 19..., to 9/9/24, 1924.

that I last saw h... alive on 9/9/24, 19...

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Renal Abscess

(duration) ..... yrs. ..... mos. 17 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? Yes Date of 8/7/8

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Philip Jacobson, M. D.

, 19 (Address) Hebrew Asylum

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Sept 10 1924

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90116

CERTIFICATE OF DEATH.

1852 90116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes Aitken

(a) RESIDENCE NO. 2596 Woodbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or ~~divorced~~ (HUSBAND of or) WIFE of: Robert M Aitken

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: About 63 Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: John Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elizabeth Dre.

12 MAIDEN NAME OF MOTHER: Agnes Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine R Saunders

(Address) 1427 Baltimore St.

SEP 10 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8th 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-22, 1924, to 9-8, 1924, that I last saw her alive on Sept 8, 1924, and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis; Laceration of scalp

(duration) yrs. mos. ds.

*Where there was disease contracted, if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) ac manninger M. D.

(Address) Colonial Hosp 9-9, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Sept 10 1924

20 UNDERTAKER: J. M. Cook — ADDRESS: 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

327 N. Carrollton Ave
Bil 05347 8/

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90117

CERTIFICATE OF DEATH.

D 90117

1574

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 509 Cumberland St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estalinda Filchette

(a) Residence No. 509 Cumberland St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George.

6-DATE OF BIRTH (month, day and year) Aug 23 1847

7-AGE. 80 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Va

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14-

(Informant) Mrs Wm Dawson

(Address) 509 Cumberland St

15-

Filed ..... 19.. .....

Registrar.

SEP 10 1924

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 9 1924

17- I HEREBY CERTIFY, That I attended deceased from June 19 24 to Sept 9 19 24

that I last saw her alive on Sept 8 19 24

and that death occurred, on the date stated above, at 10-40 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

3 wks

(Duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Karl Kummeller M. D

9/9, 1924 (Address) 327 N. Carrollton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Sept 11 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Lt. St.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 ✓ D 90118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 Whatcoat ST., 16 WARD)

2-FULL NAME Viola Brown

(a) RESIDENCE NO. 1145 Whatcoat ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 28-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Nsme of employer

9 BIRTHPLACE (city or town) (State or country): Wilmington N. C.

PARENTS

10 NAME OF FATHER: William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilmington N. C.

14 Informant: John B Landy

(Address): 1145 Whatcoat

Filed SEP 10 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1924, to Sept 8th, 1924, that I last saw her alive on Sept 8th, 1924, and that death occurred, on the date stated above, at 4 35 P.M.

The CAUSE OF DEATH* was as follows:

Appendiceal Abscess

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix Peritonitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm. Edw. Bell M.D.

, 19 (Address) 1224 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 9/10/24

20 UNDERTAKER: David Easton — ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90119

CERTIFICATE OF DEATH.

40 D 90119

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Ward H. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris

(a) Residence No. 780 W. Mulberry Street Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. Known mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Edward Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Hospital Records

(Address) Bay View Hospital Ward H.

15- Filed SEP 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-7-24

17- I HEREBY CERTIFY, That I attended deceased from 9-5-24, 19..... to 9-7-24, 19.....

that I last saw h. alive on 9-7-24, 19.....

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Extensive urinary infiltration of Genitals, Perineum + Abdominal Wall. Multiple urethral Stricture (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-7-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory test.

(Signed) Wm. F. Champe M.D. M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. 9/10/24

20-UNDERTAKER. Emil Easton ADDRESS 916 Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 90120 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74-001

CERTIFICATE OF DEATH.

D 90120
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital 4 WARD)

2-FULL NAME Allen J. Smith

(a) RESIDENCE No. 6 S. Pennsalley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None at present

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Henrietta Smith
(Address) 6 S. Penn alley

15 SEPT 10 1924
Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hundley, M. D.
(Coroner.)
Sept 10, 1924 (Address) 700 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., 1 ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 6 Penn alley

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont Olivet	9/10 1924
20 UNDERTAKER David Eston	ADDRESS 716 Penna Ave

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 90121

REGISTERED NO. D 90121

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Gilford Ave St.) (WARD) 17

2-FULL NAME Baby Brandon

(a) RESIDENCE No. 2321 Gilford Ave St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: aa

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ud

(b) General nature of industry, business, or establishment in which employed (or employer): ud

(c) Name of employer: ud

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph L Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Rosa B Norman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address)

15 Filed SEP 10 1924 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924, to Sept 9, 1924, that I last saw he alive on Sept 9, 1924, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Physical condition of Mother + Premature Birth

(duration) yrs. 4½ mos ds.

CONTRIBUTORY (Secondary) Physical condition of Mother (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo H Hall, M. D.

19 (Address) 1916 E 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 90122

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 90122

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Baltimore Md. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard L. Linton

(a) RESIDENCE No. 1117 Ridgely ~~Ave~~ ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6 wks-	1	6 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Linton

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md-

12 MAIDEN NAME OF MOTHER Katie Hill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md-

14 Informant George E. Linton
(Address) 1117 Ridgely st

15 SEP 10 1924 HUBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-16 1924, to 9-9- 1924,

that I last saw him alive on 9-9- 1924,

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Malnutrition Diarrhea, Septic infection following an infective dermatitis.

Since birth (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic infection following infective dermatitis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 10 1924
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90123

CERTIFICATE OF DEATH.

x 179

D 90123

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Eichelman

(a) RESIDENCE NO. Halethorpe Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. / ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) March 28/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph. Eichelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose A. Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rossville Md.

14 Informant Joseph Eichelman
(Address) Halethorpe Md

15 Filed SEP 10 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9/24 92

17 I HEREBY CERTIFY, That I took charge of remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Carbolic Burns over arms & legs.

(duration) ..... yrs. ..... mos.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos.

(Signed) J. H. Pale (Coroner)
9/9/24 192 (Address) 508 E. north

*State the Disease Causing Death, or in deaths from Violent state (1) Means and Nature of Injury, and (2) whether Ac Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mo

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DAT

20 UNDERTAKER James Dignan & Son

Spec.—1-10-21—M&T—1500 Bks.

D 90124 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

July 1033
D 90124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 N. Appleton ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Berkowitz

(a) RESIDENCE NO. 1732 N. Appleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Berkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Bloom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis Berkowitz 1732 Appleton St.

SEP 10 1924 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 28 1924, to Sept 10 1924,
that I last saw her alive on Sept 9 1924,
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:

Foetal Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? Visual

(Signed) Edw. Armand, M. D.

1924 (Address) 1929 E. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 9/10 1924

20 UNDERTAKER Abel Linman & Bro

ADDRESS E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90125

CERTIFICATE OF DEATH.

113 D 90125

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 S. Rose Street St., 1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Tadeusz Matuszewski

(a) Residence No. 721 S. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 4 1924

7-AGE, ... yrs. 4 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, John. Matuszewski

11-BIRTHPLACE OF FATHER (city or town) Wilmington
(State or Country). Del.

12-MAIDEN NAME OF MOTHER, Antonina Prilla

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country). Md.

14- (Informant) Mr John. Matuszewski

(Address) 721 S. Rose Street

15- SEP 10 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 9 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 19 24 to Sept 9 19 24

that I last saw him alive on Sept 9 19 24

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cause Gastro-Enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. L. Keating M. D

9/9 19 24 (Address) 702 E. Balt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem.	Sep. 10 1924

20-UNDERTAKER.	ADDRESS
John A Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 90126

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

113 D 90126

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1738 Thame St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester A. Kopczynski

(a) Residence No. 1738 Thame St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Feb. 27 1924

7-AGE. ..... yrs. 6 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Wladyslaus Kopczynski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Stanislawa Struzykowska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Mrs. Stanislawa Kopczynski

(Address) 1738 Thame Street

15- Dated SEP 10 1924 192 ROBERT R. KRAUTH, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 9 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 24 to Sept 9 24

that I last saw h... alive on Sept 8 24

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ..... yrs. 25 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) William Hyland M. D.

19- (Address) 20 N. Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem.	Sep. 10 1924

20-UNDERTAKER. John M Weber

ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90127

CERTIFICATE OF DEATH.

X 57

D 90127

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St.Joseph Hospital ST., 9 WARD)

2-FULL NAME Margaret E.Walters

(a) RESIDENCE NO. Chesnut Ave. Parkeville, Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis P.Walters

6 DATE OF BIRTH (month, day, and year) March 19/1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Fred. Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Blumenauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Athhur W. Walters
(Address) 11110 McDonough St

15 SEP 10 1924 Robert P. Harrison, M.D.
Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene rt hand

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Kolb, M. D.
(Coroner.)

9/10/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 12 192 4
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90128

CERTIFICATE OF DEATH.

x 170

D 90128

1-PLACE OF DEATH Southern Hotel.

REGISTERED NO.....

CITY OF BALTIMORE: (No. Light & Redwood Sts. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W.Cecil Ernst..

(a) RESIDENCE NO. Brawley California. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Frank Salisbury.
(Address) 800 Investment Bldg. Wash. D. C.

SEP 10 1924

File No. .....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:
Laceration of the Brain. Pistol shot wound in the head.
Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)
Sept. 10, 1924. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park for Cremation to Glendale Cemetery

DATE OF BURIAL Sept 10 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 90 D 90129

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 347 E. Clinton St. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia M. Wintuling.

(a) Residence No. 347 S. Clinton St., 76 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ambrose Wintuling.

6-DATE OF BIRTH (month, day and year) Sept. 29 1856

7-AGE. 67 yrs. 11 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) At home.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, Henry Steinbach.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

11- (Informant) Mrs. Joseph J. Elberts

(Address) 700 S. Clinton St.

15- SEP 10 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Sept 7 1924 that I last saw her alive on Sept 6 1924 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myo-Endocarditis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) 15 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examn

(Signed) Wm R. Straight M. D

9/8 1924 (Address) 203 E. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL. Sept. 11th 1924

20-UNDERTAKER. Lilly & Zeiler. ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90130

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1327 Myrtle ave, ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Adams

(a) RESIDENCE No. 1327 Myrtle ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Adams

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Woodland

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Stella Carroll
(Address) 1327 Myrtle ave.

Filed SEP 10 1924, 192 ..... Robert F. Garrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Gastro enteritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Dilatation of Heart 5 mins.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Sept. 9, 1924 (Address) 208 Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 11 1924
20 UNDERTAKER	ADDRESS
Jam[illegible] H. Chase Son	1400 Mosher

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 90131

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sommers

(a) Residence No. 319 S. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Katherine Sommers

6-DATE OF BIRTH (month, day and year) Dec 25, 1864

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman

(b) General nature of Industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER John Sommers Do not Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER " " " Margaret Sinnot

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland "

11- Mary A. Thornton

(Informant)

(Address) 319 S. Fulton Ave

13- Robert P. Harrison, M.D.

Registrar

CP 1 01924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/8/24

17- I HEREBY CERTIFY, That I attended deceased from 8/27 19 24 to 9/8 19 24

that I last saw h~~im~~ alive on 9/8 19 24

and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-Pneumonia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tabes dorsalis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Damian P. Algeo M. D.

, 19 (Address) 336 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. Sept. 12, 1924

20-UNDERTAKER. Harry H. Witzke ADDRESS 1531 W. Lombard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90132 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. WARD) 19

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elmira Schueler

(a) RESIDENCE No. 1303 W. Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E

6 DATE OF BIRTH (month, day, and year) Sept 9th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schueler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed Sept 14th, 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1924, to Sept 10th, 1924.

that I last saw him alive on Sept 10th, 1924,

and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured appendix; Localized Peritonitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes, Date of Sept 2nd, 24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Manninger, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 13 1924

20 UNDERTAKER	ADDRESS
Harry H. Weitzel	1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 90133

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-8 D. 90133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Chatham ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Eddie Scott

(a) RESIDENCE NO. 1213 Chatham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lilly Scott

6 DATE OF BIRTH (month, day, and year) Jan 6 1892

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cab 140

(b) General nature of industry, business, or establishment in which employed (or employer) Trimmer at steel mill

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) (State or country) Elmwood Co. Va.

PARENTS

10 NAME OF FATHER Willis Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Bludge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elmwood Co. Va.

14 Informant John Daisy

(Address) 1213 Chatham

15 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/1924

17 I HEREBY CERTIFY, That I attended deceased from 9/8/24, 19 24, to 9/9/24, 19 24, that I last saw him alive on 9/8/24, 19 ....., and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) J. C. Jackson, M. D.

9/9 19 24 (Address) 808 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Lebanon Cemetery Elmwood Co Va. Sept 10 24

20 UNDERTAKER ADDRESS

Mrs. R. G. Elliott 1725 Division

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

EP1 01924

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90134

CERTIFICATE OF DEATH.

111-002 D 90134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kanon

(a) RESIDENCE No. 1709-E. Oliver St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kanon.

6 DATE OF BIRTH (month, day, and year) 9/15 1874

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
49	11	24	~~If LESS than 1 day ...hrs. or ...min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Camden N J

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hebrew Hospital (Address)

15 Robert P. Harrison, . 19 Registrar

Burial Permit Clerk.

EP 1 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/24. 19

17 I HEREBY CERTIFY, That I attended deceased from 7/15/24, 19 ..., to 9/9, 1924.

that I last saw her alive on 9/9, 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Shock following operation (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/9/24

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Signs

(Signed) J. Philip Davidson M. D.

. 19 (Address) Hebrew Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem. Pikesville Md.

DATE OF BURIAL 9/11/24 19

20 UNDERTAKER Geo. J. Puth

ADDRESS 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90135 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90135

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Mc Henry ST., WARD)

2-FULL NAME Lillian Blanche Morgan

(a) RESIDENCE NO. 1416 Mc Henry ST., 19 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Morgan.

6 DATE OF BIRTH (month, day, and year) July 20-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Seelye

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Mary Elizabeth Rund

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Anne Arundel Co., Md.

14 Informant Mary Elizabeth Seelye.
(Address) 1416 Mc Henry St.

Filed SEP 10 1924 Robert P. Garrison
, 19
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9-1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to Sept 9-, 1924.
that I last saw her alive on Sept 8, 1924,
and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Riland, M. D.

(Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Sept 12 1924

20 UNDERTAKER Harry H Amoroso ADDRESS 4204 Ridgewood Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

145-1003 ✓

D 90136

CERTIFICATE OF DEATH.

D 90136

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1003 Mc Donough St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Gentry

1003 Mc Donough

(a) Residence No. 835 N. Wolfe St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of T. R. Gentry

6-DATE OF BIRTH (month, day and year) Dec 9-1905

7-AGE. 18 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS

10-NAME OF FATHER. Wm Botsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto.

12-MAIDEN NAME OF MOTHER. Josephine Berger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) T. R. Gentry

(Address) 1003 Mc Donough St

SEP 11 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 9-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 9, 19 24 to Sept 9, 19 24

that I last saw h[illegible] alive on Sept 9, 19 24

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Pregnant and delivered

Acute Mitral Regurgitation

(Duration) 9 yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. W. Bunting M. D.

10-11-24 (Address) 800 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Lawn. DATE OF BURIAL, Sept 12" 1924

20-UNDERTAKER, Geo M. Trimble Son ADDRESS 611 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90137

Registered No. 15 125 D 90137

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Christian

(a) Residence No. 1340 N. Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Starech Christian

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?a

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14-(Informant) Municipal Hospital Records

(Address)

15-

SEP 11 1924

ROBERT R. KRAMER, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-8-24

17- I HEREBY CERTIFY, That I attended deceased from 3-5, 1921, to 9-8, 1924, that I last saw h[illegible] alive on 9-8, 1924, and that death occurred, on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude C. Howard, M. D.

9-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL, Sept 11, 1924

20-UNDERTAKER. John H. Toadvine ADDRESS 1027 Hanover Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90138

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Hippler

(a) Residence No. 3220 Leeds Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced: married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Hippler

6-DATE OF BIRTH (month, day and year): May 30, 1903

7-AGE: 21 yrs. 3 mos. 9 ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work:

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Edgar L. Hannon Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): " " Md

12-MAIDEN NAME OF MOTHER: Betty Bowers " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-Informant: Andrew E. Hippler

(Address): 3108 Gilmor

15-Filed SEP 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9/8/24.

17-I HEREBY CERTIFY, That I attended deceased from August 23, 1924 to Sept 8th 1924,

that I last saw her alive on 9/8 1924,

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) yrs. mos. 16 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes X Date of 8/27/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D

, 19 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 11, 1924

20-UNDERTAKER: Harry L. Nitzke — ADDRESS: 1531 N. Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 90 D 90139

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2017 Ellsworth St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Dittmar

(a) Residence No. 2017 Ellsworth St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Johanna P. Dittmar

6-DATE OF BIRTH (month, day and year): Jan 24/47

7-AGE. 77 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Hair Factory
(c) Name of employer: Rayport Co.

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.
10-NAME OF FATHER: John Dittmar
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Johanna P. Dittmar
(Address): 2017 Ellsworth St

SEP 11 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 9/24

I HEREBY CERTIFY, That I attended deceased from Sept 8 1923 to Sept 9 1924
that I last saw h[illegible] alive on Sept 8 1924,
and that death occurred, on the date stated above, at 11 10 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Arteriosclerosis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) F. E. Hamer M. D
Sept 11 1924 (Address) 130 W Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Sept 11, 1924

20-UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90140

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

D 90140
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2138 E. Oliver ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida V. Deise

(a) RESIDENCE NO. 2138 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10. 1924

7 AGE — Years — Months — Days — If LESS than 1 day, 11 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER A. Miles Deise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Ida V. Hudnutt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant A. Miles Deise
(Address) 2138 E. Oliver St

15 [illegible]

SEP 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1924, to Sept. 10, 1924, that I last saw he alive on Sept. 10, 1924 and that death occurred, on the date stated above, at 6:01 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity - 1 mos.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Separation Placenta

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Arthur Hoffheimer Jr., M. D.

Sept 11, 1924 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Sept 11 1924

20 UNDERTAKER: Wm E Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1924 SD 74

D 90141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90141
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2031 Penna ST. 14 WARD) 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert R. Green

(a) RESIDENCE. No. 2031 Penna ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored.	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Gertrude Green.

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wesley Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Gertrude Green
(Address) 2031 Penna ave.

15 SEP 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1924, to Sept 7, 1924, that I last saw h[illegible] alive on Sept 8, 1924, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Errors of diet

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Lee D. Woodridge, M. D.

9/10 1924 (Address) 1633 Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 11 1924

20 UNDERTAKER Mr Sgames H. Dennis

ADDRESS 1303 Freestman St

HEALTH DE... CITY OF BALTIMORE

D 90142

CERTIFICATE OF DEATH.

181-00

D 90142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 W Lexington St ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Hartt (or Hurt)

(a) RESIDENCE No 748 W Lexington St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Rev. Johnson
(Address) 1400 B E Eastern Ave

15 Filed SEP 11 1924 ROBERT P. KRAUTH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Inhalation Deliberate

(duration) ..... yrs. a few mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Accidental

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

, 192 4 (Address) 670 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cemetery

DATE OF BURIAL 9/11 192 4

20 UNDERTAKER George J Ruth

ADDRESS 1135 Hanford

Spec—12-23-21—E.B.R.S.—400 Bks.

90143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002

D 90143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert G. Cof, Ja.

(a) Residence No. 701 S. Robinson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 5-1924

7-AGE. ....yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto., Md.

PARENTS

10-NAME OF FATHER. Robt. G. Cof.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto, Md.

12-MAIDEN NAME OF MOTHER. Catharine Kram

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto, Md.

14-

(Informant) Robt. G. Cof

(Address) 701 S. Robinson St.

15-

SEP 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1924 to Sept 9 1924

that I last saw him alive on Sept 8 1924

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Frances Tilton M. D.

, 19 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart	Sept 11 1924
20-UNDERTAKER. Zirkler + Zirkler	ADDRESS 1737 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90144

CERTIFICATE OF DEATH.

90 D 90144

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3713 Chestnut Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie E. Lyons

(a) RESIDENCE No. 3713 Chestnut Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of P. J. Lyons

6 DATE OF BIRTH (month, day, and year) Apr. 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph T. Roseberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Cornelia Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant P. J. Lyons (Address) [illegible]

15 Filed SEP 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924, to Sept 9, 1924, that I last saw h[illegible] alive on Sept 9, 1924, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Hypertrophy Heart

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia + Chronic Nephritis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin A. Stark, M. D.

9.10. 1924 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Sept. 12, 1924

20 UNDERTAKER Wm. C. Black 927 N. Broadway

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90145

CERTIFICATE OF DEATH.

100-001 D 90145

1-PLACE OF DEATH Church Home + Infirmary.

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice B. Shew.

(a) RESIDENCE NO. 3916 Woodland Av. Forest Park. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William H Brent

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Harry F Shew
(Address) 3916 Woodland Av Forest Park

15 Filed SEP 11 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1924

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to Sept 9th, 1924, that I last saw her alive on Sept 9th, 1924, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Spinal cord tumor.

over

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes. Date of May 24. 24.

Was there an autopsy? yes.

What test confirmed diagnosis? .....

(Signed) George B Breed, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 11 19 24
20 UNDERTAKER George J Smith	ADDRESS 1652 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90146

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Dunmore Can ST.: 27 WARD)

2-FULL NAME Alexander Henson

(a) RESIDENCE. No. 327 Dunmore Can ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Col.	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Henson

6 DATE OF BIRTH (month, day, and year) 1843 Mch.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
81	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) Gardner

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Just Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel J. Henson
(Address) 333 Falls Rd

15 Filed SEP 11 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 4/24, 19..., to Sept 9, 19 24,
that I last saw h... alive on Sept 9, 19 24,
and that death occurred, on the date stated above, at 2 9 m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Howard Lull, M. D.

9/11 19 (Address) Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cem	Sept 11 24
20 UNDERTAKER	ADDRESS
Edward L Handley	1128 Eddie

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Martha G. Burrill Thompson)

D 90147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 90147

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 752 Lanvale ST.; (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha G Burrill Thompson

(a) RESIDENCE. No. 752 Lanvale ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Mary Wright 752 Lanvale St

15 Filed SEP 11 1924, 19 Robert P Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1924, to Sept 9, 1924, that I last saw h[illegible] alive on Sept 8, 1924, and that death occurred, on the date stated above, at 2 A., m.

The CAUSE OF DEATH* was as follows: Cardiac Arrest Contributory

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home 7

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Arteriosclerosis Symptoms

(Signed) Charles H Fowble M. D.

Sept 9 1924 (Address) 712 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 11 1924

20 UNDERTAKER: Arnold O'Grady ADDRESS: 1[illegible] Pa

Spec.—1-10-21—M&T—1500 Bks.

D 90148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1129 D 90148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Poplar Grove St. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Rebecca Magers

(a) RESIDENCE NO. 1801 Poplar Grove St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Magers

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Co. Maryland

PARENTS

10 NAME OF FATHER Saml. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz. Shanklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

14 Informant Wm. A. Magers W.F.
(Address) 1801 Poplar Grove St.

15 Filed SEP 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10th 1924

17 I HEREBY CERTIFY, That I attended deceased from August 16th, 1922, to September 9th, 1924, that I last saw her alive on September 9th, 1924, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

. 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Sept 12 1924

20 UNDERTAKER Wm. H. Tickner & Son W.F.

ADDRESS North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and public institutions CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90149

CERTIFICATE OF DEATH.

91-002 D 90149

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 19 Mallowhill Ave. ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Felicita Joyce

(a) RESIDENCE No. 19 Mallowhill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. N. Joyce

6 DATE OF BIRTH (month, day, and year) Mch. 9. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Plunkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm. Joyce W.J.T.

(Address) 19 Mallowhill Ave.

15 SEP 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 6. , 1924 , to Sept. 9, , 1924 , that I last saw her alive on September 9, 1924 , and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Typ.

Senile Dementia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw J Coolahan M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 12 1924

20 UNDERTAKER: Wm. J. Tickner & Sons — ADDRESS: North Ave

W.J.T.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90150

CERTIFICATE OF DEATH.

90 D 90150

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1415 Linden Ave 14 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Bayly

(a) Residence No. 1415 Linden Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Bayly

6-DATE OF BIRTH (month, day and year) Oct. 2, 1836

7-AGE. 87 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Va

PARENTS:

10-NAME OF FATHER, Solomon Copes.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Scott

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va.

14- (Informant) Louisa A Bayly

(Address) 145 Linden Ave

SEP 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 10. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1. 1924 to Sept. 10. 1924

that I last saw h.. alive on Sept 10 1924

and that death occurred, on the date stated above, at 7.30 P M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Old Age

(Duration) ..... 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Robert E. Blake M. D

, 19 (Address) 1014 W Lafayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Sept 13 1924

20-UNDERTAKER: Wm Fleckenstons ADDRESS: North Ave

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

174366 D 90151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Mayo

(a) RESIDENCE NO. Fremont, N. C. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER Fernan Mayo

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER Viola Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Friend

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Sept 11, 1924, that I last saw him alive on Sept 11 - , 1924, and that death occurred, on the date stated above, at 12 50 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis
Arterio sclerosis.
Hypertension

(duration) ..... yrs. 4 mos ? ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1-2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Bill Stuebner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fremont N. Carolina — DATE OF BURIAL: Sept. 11 1924

20 UNDERTAKER: Richard F. Curley — ADDRESS: 108 Guilford Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90152

CERTIFICATE OF DEATH.

14 161-09

D 90152

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1320 Smael St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wallace

(a) Residence No. 1320 Smael St. St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Negro.

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9/9/24

7-AGE, 0 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Fairfield Lafayette Wallace

11-BIRTHPLACE OF FATHER (city or town) Fort Smith, Va (State or Country),

12-MAIDEN NAME OF MOTHER, Viola Jennifer

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) St Mary's Co Md

14- (Informant) Fairfield Wallace

(Address) 1320 Smael

15-

Filed..... Oct 1924 Registrar.

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/10/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1924, to Sept 10 1924, that I last saw her alive on Sept 10 1924, and that death occurred, on the date stated above, at 4 30 P.M. The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Bauers M. D

9-10, 1924 (Address) 1702 Westwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse side for additional space.)

19-NAME OF BURIAL, CREMATION OR REMOVAL. Mt Lebanon

DATE OF BURIAL. Sept 12, 1924

20-UNDERTAKER. Sam W Close Son

ADDRESS 1400 Mosher

P. T. O.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90153

CERTIFICATE OF DEATH.

90 D 90153

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Grace Brown

(a) Residence No. 122 Rock St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1844

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore, Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm Brook

11-BIRTHPLACE OF FATHER (city or town). Baltimore, Md
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). Baltimore, Md
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed. Robert P. Harrison, Registrar.

SEP 11 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-9-24

17- I HEREBY CERTIFY, That I attended deceased from 7-24 1924 to 9-9 1924

that I last saw h.. alive on 9-9 1924

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis (Degenerative)

Myocardial Insufficiency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Stone M. D.

9-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Sept 12, 1924
20-UNDERTAKER.	ADDRESS
John H Owens	538 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Joseph's Hosp St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse A Harden

(a) Residence No. Pikesville md St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lucy B Harden

6-DATE OF BIRTH (month, day and year) July 15/1857

7-AGE. 67 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Carroll co Md

PARENTS.

10-NAME OF FATHER, John W Harden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Sophie Patterson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Jesse A Harden

(Address) Pikesville Md

15- Filed SEP 1 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 19 24 to Sept 11 19 24

that I last saw h. alive on Sept 11 19 24

and that death occurred, on the date stated above, at 2:45A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, arteriosclerosis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of left foot

(Duration) yrs. 15 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo B Dysart M. D.

19 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Pleasant Cem Gamber Md	Sept 13 19 24
20-UNDERTAKER.	ADDRESS
Harry N Armacost	4204 Ridgewood Ave

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 90155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90155

147

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Ward A. St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angella Bayton

(a) Residence No. 1700 Asquith St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1887

7-AGE 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-

(Informant) Hospital Records

(Address) Bay View Hospital

15-

Filed SEP 11 1924

Robert P. Harrison, Registrar.

1761

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-8-24

17- I HEREBY CERTIFY, That I attended deceased from 8-23-24 19.. to 9-8-24 19..

that I last saw her alive on 9-8-24 19..

and that death occurred, on the date stated above, at 12 25 p.m.

The CAUSE OF DEATH* was as follows:

Extensive Cerebral Thrombosis

Right Sided Hemiplegia

Hemorrhage Brain 2nd Pregnancy.

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pre-eclamptic Toxemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-5-24

Was there an autopsy? None

What test confirmed diagnosis? Clinical & Laboratory Ex.

(Signed) R. P. Harrison M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19..

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

SEP 11

Per Wm. E. Woodward

Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90156 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90156

CERTIFICATE OF DEATH.

161-801

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Asylum St., No ..... Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bayton

(a) Residence No. Ward N. Bay View Hospital St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year)

7-AGE. ..... Yrs. ..... mos. 1mo ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Agnetta Bayton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Hospital Records

(Address) Bay View Hospital.

15- Filed ..... 192 .....
Registrar.

SEP 11 1924

1762

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-7-24.

17- I HEREBY CERTIFY, That I attended deceased from 9-5-24 19.... to 9-7-24 19....

that I last saw h[illegible] alive on 9-7- 19 24

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months).

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab. Tests

(Signed) Jas. P. Plumpe M. D.

(Address) Bay View Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. | DATE OF BURIAL, ... 19....

20-UNDERTAKER. | ADDRESS

Robert P. Harrison,

Burial Permit Clerk.

UNIVERSITY OF MARYLAND

Commissioner of Health.

Per. Wm. E. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90157 D 90157

7128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Jefferson

(a) RESIDENCE NO. Greensboro N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Life Insurance Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greensboro, N.C.

PARENTS

10 NAME OF FATHER W C. Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Nearby, Johns Hopkins Hosp.
(Address)

15 Filed SEP 11 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1924, to Sept 10, 1924,

that I last saw her alive on Sept 10, 1924,

and that death occurred, on the date stated above, at 8 55 P. m.

The CAUSE OF DEATH* was as follows:-

Acute nephritis.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Greensboro- N.C.

Did an operation precede death? No Date of

Was there an autopsy? ~~No~~ yes.

What test confirmed diagnosis?

(Signed) Fred A Allen M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenbrara N.C.	Sept 11 1924
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90158

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 511-N-Stricker St., 19 Ward)

Registered No.....

2-FULL NAME Sarah Mitchell Conley

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 511-N-Stricker St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. 6 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. F. Conley

6-DATE OF BIRTH (month, day and year) Feby-24-1858

7-AGE, 66 yrs. 6 mos. 16 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Lancaster Co. Virginia

PARENTS.

10-NAME OF FATHER, Wm. G. Mitchell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lancaster Co. Va.

12-MAIDEN NAME OF MOTHER, Sarah Sorrell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lancaster Co. Va.

14- (Informant) Mrs. J. Conley - (Husband)

(Address) 511-N. Stricker St.

15- Filed SEP 1 1924, 19.. Robert F. Morrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 9-1924

17- I HEREBY CERTIFY, That I attended deceased from March 19 24 to Sept 9, 19 24

that I last saw h.. alive on Sept 9, 19 24

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Enlarged Fibroid Tumor (abdominal)

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemmorrhages & Diabetes Complicating

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Tyndman M. D.

9/9, 1924 (Address) 2002 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cemetery | DATE OF BURIAL, Sept 12, 1924

20-UNDERTAKER STEWART & WOODEN COMPANY (WILLIAM F. WOODEN, Successor) | ADDRESS 108 W. NORTH AVE

Dist. Health Clerk

...IS A PERMANENT RE... ...ed EXACTLY. PHYSICIAN ...ed. Exact statement of OC... should be carefully supplied. AGE should be stated EX... in plain terms, so that it may be properly classified. E... instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90159

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 17 Ward) Registered No. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Markey

(a) Residence No. Homewood Apts St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 45 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rose Claggett Markey

6-DATE OF BIRTH (month, day and year) May-9-1861

7-AGE. 63 yrs. 4 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Grocer

(b) General nature of industry, business, or establishment in which employed (or employer). Grocers 034

(c) Name of employer. Retired

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). " Don't Know

12-MAIDEN NAME OF MOTHER. " Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " Don't Know

11- (Informant) Thos. Foley Torsky atty

(Address) 210 N. Charles St

15- Filed ....., 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

SEP 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 26th 1924 to Sept. 9 1924, that I last saw h[illegible] alive on Sept 9th 1924, and that death occurred, on the date stated above, at 4.15 P m. The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma Prostate

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Austin A. Hood M. D

Sept 9 1924 (Address) 917 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. Sept 12 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH AVE.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90160 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90160

100-20

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Nottingham Way Overhill Rd. St. 28 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Charles William Gardner

(a) Residence No. Nottingham Way Overhill Rd. St., ... Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 54 yrs. 9 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elsie Cintli Gardner

6-DATE OF BIRTH (month, day and year) Nov-14-1869

7-AGE, 54 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chief Clerk-Railway

(b) General nature of industry, business, or establishment in which employed (or employer) Mail Servic

(c) Name of employer U. S. Government

9-BIRTHPLACE (city or town) B. & O. Co.
(State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Samuel Gardner

11-BIRTHPLACE OF FATHER (city or town) B. & O. Co.
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eliza Bevan

13-BIRTHPLACE OF MOTHER (city or town) B. & O. Co.
(State or Country), Md.

14- (Informant) Mrs Elsie C. Gardner (wife)

(Address) Fenwicks - City.

15- Filed SEP 1 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 29, 1923, to Sept 10, 1924, that I last saw him alive on Sept 9, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Primary anemia

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. D. Rowe, M. D.

Sept. 11, 1924 (Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Sept 12, 19 24.

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. MONTH AVE.

THIS IS A PERMANENT RE... should be carefully supplied. AGE should be stated E... in plain terms, so that it may be properly classified. Exact statement of OC... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90161

CERTIFICATE OF DEATH.

167-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square) (Hospital) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Nelson

(a) RESIDENCE NO. 1035 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Llewellyn N. Nelson

6 DATE OF BIRTH (month, day, and year) Nov. 8th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Upper Fairmount Md.

PARENTS

10 NAME OF FATHER Steven Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Llewellyn N. Nelson (Address) 1024 N Patterson Park Ave

15 Filed Sept 10, 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhaling Illuminating Gas

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Chas. B. Norton, M. D. (Coroner.)

Sept 10, 192 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF Sept

20 UNDERTAKER George Smith — ADD 1

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 1 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90162

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 N. Robinson St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Guenther

(a) Residence No. 415 N. Robinson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 15, 1864

7-AGE, 60 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Anton Rebes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Leonard Neuhardt

(Address) 415 N. Robinson St.

15- Filed ..... 19.. Registrar.

SEP 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-16-24

17- I HEREBY CERTIFY, That I attended deceased from May 1 to Sept 16 19 24

that I last saw ... alive on Sept 9 19 24

and that death occurred, on the date stated above, at 3 A ... m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach

Contributory (Secondary) Cardiac Dilatation

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Burnside M. D.

9-11 19 24 (Address) 2004 Bath St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept 13, 19 24
20-UNDERTAKER, George J. Smith	ADDRESS 1532 Hollins St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. (Furlong)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90163 D 90163

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 Lancaster St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Furlong

(a) Residence No. 1516 Lancaster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6-DATE OF BIRTH (month, day and year) July 8. 1867.

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS

10-NAME OF FATHER, John Furlong

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mrs Mary Ruth (Address) 1516 Lancaster St.

15- Filed 192 Registrar.

SEP 11 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 24 to Sept 10 19 24

that I last saw h.. alive on Sept 10 19

and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro sclerosis, contributory stenosis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia & Heart failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) Thos A Culbreth M. D.

9/10, 1924 (Address) 1623 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cemetery	Sept 11, 1924

20-UNDERTAKER	ADDRESS
Model Funeral Directors	5 E Franklin

SEE INSTRUCTIONS ON BACK. WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D 90164

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 8 WARD)

2-FULL NAME Michael K. Schellenberger

(a) RESIDENCE NO. 1509 N. Milton Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 43 yrs. ---- mos. ---- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~XXXXXXX~~ Catherine S. Schellenberger.

6 DATE OF BIRTH (month, day, and year) July, 7, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer G.B.S. Brewing Co.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER August Schellenberger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine S. Schellenberger.

(Address) 1509 N. Milton Ave.

15 Filed SEP 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner.)

Sept. 11, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Charles & Lombard St. Sept. 10, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cmtry DATE OF BURIAL Sept. 13 1924

20 UNDERTAKER Henry Koch & Son ADDRESS 1201 E Eager St

N.B.—WARNING, WITH CONDITIONS OF PENALTY, FALSE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90165

CERTIFICATE OF DEATH.

129 D 90165

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1539 N. Milton Ave. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Stone

(a) Residence No. 1539 N. Milton Ave St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of ~~(or WIFE)~~ of the late Elnora Stone.

6-DATE OF BIRTH (month, day and year) February 16 1850

7-AGE. 74 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 130

(b) General nature of industry, business, or establishment in which employed (or employer)..... Engineer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Carroll Co. Md

PARENTS.

10-NAME OF FATHER. William H. Stone

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co. Md

12-MAIDEN NAME OF MOTHER. Marcella Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll Co. Md

14- (Informant) Mrs Cora Paige

(Address) 1539 N. Milton Ave

SEP 12 1924 ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924 to Sept 10 1924

that I last saw him alive on Sept 10 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of urine

(Signed) Robt H Greim M. D

9-11 1924 (Address) 120 Cleveland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery DATE OF BURIAL. Sept 13, 1924

20-UNDERTAKER. Henry Hoeck Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90166

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 74 B 90166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2025 N. Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Hughes Steele

(a) Residence No. Cambridge Md. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Guy Steele

6-DATE OF BIRTH (month, day and year) March 27. 1866

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House duties

(b) General nature of industry, business, or establishment in which employed (or employer)..... 31

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va.
(State or Country),

PARENTS.

10-NAME OF FATHER Hugh H. Hughes

11-BIRTHPLACE OF FATHER (city or town)..... Va.
(State or Country)

12-MAIDEN NAME OF MOTHER, Sarah A. Ford

13-BIRTHPLACE OF MOTHER (city or town)..... Va.
(State or Country)

14-

(Informant)..... Dr. Guy Steele

(Address)..... Cambridge

15- SEP 12 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 11. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 ..... 1924 to Sept 11 1924

that I last saw h. alive on Sept 11 1924

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

9/12. 1924 (Signed) Geo. M. Steele M. D.

(Address) 2405 Maryland ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cambridge Md. DATE OF BURIAL. Sept 13, 1924

20-UNDERTAKER. John Ouldridge ADDRESS 1201 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90167 ✓ 08 D 90167.

D 90167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. St., 20 74 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Spence. (C)

(a) RESIDENCE NO. 137 W. Hill St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 29, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Daniel Spence. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Sarah Martin. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Oliver Spence. (C) brother.
(Address) 137 W. Hill St.

15 Filed SEP 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 11, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Park Ave. & Lexington St. Sept. 8, 1924

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion — DATE OF BURIAL Sept 12 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90168

CERTIFICATE OF DEATH.

3 D 90168

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 533 W Lee St., 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnora Jones

(a) Residence No. 533 W Lee St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced (HUSBAND of ~~or~~) WIFE of Geo Jones

6-DATE OF BIRTH (month, day and year) Oct 23/1900

7-AGE. 23 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Peter Phillips

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ella Goss

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14-
(Informant) Pearl Walter
(Address) 533 W Lee

SEPT 2 1924 ROBERT S. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/11/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924 to Sept 11, 1924 that I last saw h. Ev alive on Sept 10, 1924 and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

9/11 (Signed) S. M. Earl M. D.
, 1924 (Address) 7003 Harford

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Sept 13, 1924
20-UNDERTAKER.	ADDRESS.
John H. Loadman	1027 Hundredman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17328 D 90169

57 D 90169 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Parsons

(a) RESIDENCE No. 1201 N Charles St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Parsons

6 DATE OF BIRTH (month, day, and year): March 21. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 856

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England.

PARENTS

10 NAME OF FATHER: William Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Ellen Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: [illegible] Record

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 1 2 1924 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1924, to Sept 11, 1924.

that I last saw him alive on Sept 11, 1924

and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Leg

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Blood + urine Exam.

(Signed) F. K. Reichert, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 13 1924

20 UNDERTAKER: Robt J Turner & Co

ADDRESS 1442 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90170

CERTIFICATE OF DEATH.

1824 D 90170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., 8 WARD)

2-FULL NAME Chas. H. Bowen

(a) RESIDENCE No. 1516 Rutland Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma H. Bowen

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 152
(c) Name of employer Jos. Wyneger

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Nosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma H. Bowen
(Address) 1516 Rutland Ave

15 Filed SEPT 2 1924 ROBERT A. KRAUSER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of ribs
Internal Hemorrhage
Accidental Fall from a Step Ladder
(duration) 3 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial degeneration
(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Sept. 11, 1924 (Address) 2112 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL Sept 13 1924

20 UNDERTAKER Rott & Turner — ADDRESS 649 N. Broadway

THIS IS PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90171

CERTIFICATE OF DEATH.

6 124

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. # 104 N. Kenwood ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Alexandra Pritchard

(a) Residence No. 104 N. Kenwood St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Pritchard

6-DATE OF BIRTH (month, day and year) Sept 20 1862

7-AGE. 61 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Pritchard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Evelyn Rivers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), France

14-

(Informant) Mary E Pritchard

(Address) 114 N. Kenwood

15-

SEP 12 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 11 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to Sept 11 19 24

that I last saw h.. alive on Sept 11 19 24

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur F Rawls M. D.

Sept 11 (Address) 801 N Kenwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet	Sept 13 1924
20-UNDERTAKER.	ADDRESS.
Wendell Dyer & Son	373 Ins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90172 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90172

173 12 31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Crawford

(a) RESIDENCE NO. 1330 Argyle Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) Feb 23 1924

7 AGE — Years | 6 Months | 18 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER John W Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Mary R. Dickenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address) Records Johns Hopkins Hospital.

15 Filed SEP 12 1924 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1924, to Sept 10, 1924, that I last saw him alive on Sept 10, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund A Kepler, M. D.

1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Sept 12 1924

20 UNDERTAKER: Samuel A Hunter | ADDRESS: 1728 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Solomon Jones)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90173

CERTIFICATE OF DEATH.

38 D 90173

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Asy St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johns, Solomon

(a) Residence No. 922 Brevard St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~Lena~~ Lena Jones.

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do. Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do. Do.

14- (Informant) Bay View Hospital

(Address) Baltimore, Md.

15- SEP 12 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-9-24

17- I HEREBY CERTIFY, That I attended deceased from 5/9/1924 to 9/9/1924

that I last saw him alive on 9/9/1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Synusal Paralysis

of the Insane

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No Lab. & Clinical findings.

What test confirmed diagnosis?

(Signed) H. E. Bonner M. D.

9/11, 1924 (Address) Bay View Asylum

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-NAME OF BURIAL, CREMATION OR REMOVAL. Wm. H. Coburn Co. DATE OF BURIAL. Sept 12, 1924

20-UNDERTAKER. Arnold Hemsley ADDRESS 1928 Eddes St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 90174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 111-D 90174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 431 (Street) Druid Hill Ave (Ward) 11

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Effie Baten

(a) RESIDENCE. No. 931 (Street) Druid Hill Ave (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State) South Carolina

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Early Baten

6 DATE OF BIRTH (month, day, and year) March 7-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 yrs	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Cyprus Lemmon

11 BIRTHPLACE OF FATHER (city or town) (State or country): ——

12 MAIDEN NAME OF MOTHER: ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ——

14 Informant: Early Baten

(Address) 931 Druid Hill Ave

15 Received SEP 12 1924 HUBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1924. to Sept 11th, 1924.

that I last saw h.. alive on Sept. 11th, 1924.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

General peritonitis.

following perforation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Grant Forth, M. D.

. 19 (Address) 354 W. Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: 9-12 1924

20 UNDERTAKER: Mitchell & Bailey

ADDRESS 1421 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Watson ST., 5 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Keys

(a) RESIDENCE NO. 1261 Edward St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Edward Keys
(Address) 1261 Edward St

15 Filed SEP 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured L. Kidney by fall down stair accident

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(duration) yrs. mos. 4 ds.

(Signed) James M Fenton, M. D.
(Coroner.)

Sept 10, 1924 (Address) Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Sept 12 1924

20 UNDERTAKER John W Henderson

ADDRESS 1602 E. monument

Spec.—1-10-21—M&T—1500 Bks.

D 90176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90176

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1851 N. Spring St. ST., 9 WARD)

2-FULL NAME Peter Curtis

(a) RESIDENCE No. 1851 N. Spring St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary. Curtis

6 DATE OF BIRTH (month, day, and year): Aug. 17-1852

7 AGE — Years: 72 — Months: — — Days: 24 — If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Kitchen 86

(b) General nature of industry, business, or establishment in which employed (or employer): Produce Co

(c) Name of employer: Kitchen.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: A. Adaway.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Mary. County.

14 Informant: Mary. Curtis
(Address) 1851 N Spring st.

15 Filed ..... 19..... ROBERT R. KRAUTER, Registrar
SEP 1 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): SEPT 0 1924

17

I HEREBY CERTIFY, That I attended deceased from SEP - 8 1924, 19..... to SEP - 9 1924, 19.....

that I last saw h..... alive on SEP - 9 1924, 19.....

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Anachronic Nephritis

with uremia

(duration) X yrs. X mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of X

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. H. Duker M. D.

SEP 1 9 1924 19 (Address) 928. E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary.

DATE OF BURIAL: 9/12/24 19

20 UNDERTAKER: George J. Ruth

ADDRESS: 1736 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90177 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3601 Eastern Ave. St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward William Schoepflin.

(a) Residence No. 3601 Eastern Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Schoepflin

6-DATE OF BIRTH (month, day and year) March 3-1884

7-AGE, 40 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer. 640

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil

(c) Name of employer ....do....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS

10-NAME OF FATHER, Jacob Schoepflin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-(Informant) Emma Schoepflin

(Address) 3601 Eastern Ave.

15-

SEP 1 2 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 1924 to Sept 10, 1924 that I last saw h[illegible]alive on Sept 10 1924 and that death occurred, on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

9/11, 1924 (Signed) Horace D Sutton M. D (Address) 310 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL. Sept. 13, 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every name given should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Margaret Nihill (Keough)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90178

D 90178

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S Chester ST., 7 WARD)

2-FULL NAME Margaret Nihill Keough

(a) RESIDENCE No. 118 S Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Keough

6 DATE OF BIRTH (month, day, and year) June 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) Rutland
(State or country) Vermont

PARENTS

10 NAME OF FATHER Terence Sweeny

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER M. McDugal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Earl Nihill
(Address) 118 S. Chester St

15 SEP 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Nephritis (Chronic) Arteriosclerosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Kenbum, M. D.
(Coroner.)

Sept 11, 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clinton Mass. DATE OF BURIAL Sept 15 1924

20 UNDERTAKER F. W. Ozmer Agency ADDRESS 1950 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Hue - York Rd + Harwood.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90179

3 D 90179

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4438 Wrenwood Av., 27 WARD)

2-FULL NAME Solomon R. Wright.

(a) RESIDENCE NO. 4438 Wrenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma J. Wright

6 DATE OF BIRTH (month, day, and year): July 26 1846

7 AGE — Years: 78. Months: 1 Days: 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Forehand Wagon Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Solomon C Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth V. Robertson (Wilbur)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester

14 Informant: Alexander G Wright

(Address): 4438 Wrenwood Ave

15 SEP 1 2 1924

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Sept 11, 1924, that I last saw him alive on Sept 10, 1924, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. R. Hoen, M. D.

9-11, 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park, DATE OF BURIAL: Sept 13 1924

20 UNDERTAKER: Woodcock & Matthews ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Dr Lilly 800 E North Ave Home 822 W

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90180

CERTIFICATE OF DEATH.

D 90180

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1007 Wilcox ST., 10 WARD)

2-FULL NAME Martha J Hinckley

(a) RESIDENCE No. 1007 Wilcox St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hinckley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
about	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country) Md

PARENTS

10 NAME OF FATHER Wilson Church

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Osborne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Hinckley

(Address) 1007 Wilcox St

SEP 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I attended deceased from September 4 1924 to September 11 1924

that I last saw h alive on Sept 9 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urinary analysis

(Signed) J. E. Lilly, M. D.

Sept 12 1924 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Sept 13 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90181

CERTIFICATE OF DEATH.

D 90181

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., W WARD)

2-FULL NAME Mr. Harry L. Matthews

(a) RESIDENCE No. 2340 Oak. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Addie Treadway

6 DATE OF BIRTH (month, day, and year) Mar 1 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ....min.
	54	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

013

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Treadway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs H. L. Matthews

(Address) 2340 Oak St

Filed SEPT 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1924

17

I HEREBY CERTIFY, That I attended deceased from 7-13, 1924, to 9-12-, 1924,

that I last saw him alive on 9-12, 1924,

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

chronic myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation 15 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jno Thompkins, M. D.

. 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Bur

DATE OF BURIAL Sept 15, 1924

20 UNDERTAKER Wm Leork Sons

ADDRESS Fayette

Cor.—1-12-23—M&T—100 Bks.

Theodore Stern

D 90182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X170 D 90182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Boyd

(a) RESIDENCE No. 1 Essex Caden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Stern

6 DATE OF BIRTH (month, day, and year) Mar 20. 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Catcher, Tin Mill
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Stern

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant William Rodgers
(Address) 1 Essex Ave & Eastend

15 Filed SEP 12 1924, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Suicide
Gunshot wound of head 2 hr
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. ds.

(Signed) Geo Clifford Boyd M. D.
(Coroner)
Sept 12 1924 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 15 1924
20 UNDERTAKER	ADDRESS
Wm Leavell & Son	Eutaw & Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90183

CERTIFICATE OF DEATH.

117 D 90183

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N Central Ave ST., 5 WARD)

2-FULL NAME Clarence Toled

(a) RESIDENCE NO. 431 N Central Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mamie Toled

6 DATE OF BIRTH (month, day, and year) Dec 20, 880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Roman Toled

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mariah Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Griffin Toled Brother (Address) 431 N Centre Ave

15 Filed SEP 1 2 1924 ROBERT R. KRAUTH, Registrar

Burial P...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1924 to Sept 10, 1924.

that I last saw him alive on Sept 10, 1924,

and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis and about 6 wks Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marked Anemia

(duration) uncertain yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R Krauth, M. D.

9/10, 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Sept. 13 1924

20 UNDERTAKER Mrs J. G. Locke ADDRESS 1312 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90184

CERTIFICATE OF DEATH.

x46 D 90184

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.,.....WARD)

2-FULL NAME. Mary Gilbert.

(a) RESIDENCE NO. Joppa Md. ST.,.....WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of June 19

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Ward. 037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hospital Record

15 SEP 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/24

17 I HEREBY CERTIFY, That I attended deceased from 9/5/24, 19..... to 9/11/24, 19....., that I last saw h... alive on 9/11/24 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

Pregnancy.

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ? Dr C.

Did an operation precede death? No Date of 9/11/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dolley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Joppa. Md | DATE OF BURIAL Sept 14 1924

20 UNDERTAKER Howard K McCauna | ADDRESS Aberdeen Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 90185

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1320 Smallwood St., St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wallace

(a) Residence No. 1320 Small St., St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: Negro

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/9/24.

7-AGE. 0 yrs. 0 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS

10-NAME OF FATHER: Layfield Lafayette Wallace

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Port Tobacco Md

12-MAIDEN NAME OF MOTHER: Viola Jennifer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md. Penn's Co

14-

(Informant): Fairfield Stallard

(Address): 1320 Small

15-

Filed ..... 192.... ROBERT R. KRAUTER, Registrar.

SEP 12 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9-11-24.

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1924, to Sept 11 1924, that I last saw h[illegible] alive on Sept 10 1924, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Passano M. D

9-11, 1924 (Address) 1702 Westwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon

DATE OF BURIAL: Sept 12 1924

20-UNDERTAKER: Paul F. Graef & Son

ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90186

CERTIFICATE OF DEATH.

10 09 D 90186

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jonathon Dorsey

(a) Residence No. Bay View Asylum St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1839

7-AGE. 85 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Edward [illegible]

(State or Country)

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14-(Informant) Municipal Hospital Records

(Address).....

15-Filed SEP 12 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-8-24

17- I HEREBY CERTIFY, That I attended deceased from 9-6, 1924 to 9-8, 1924

that I last saw h[illegible] alive on 9-8, 1924

and that death occurred, on the date stated above, at 10.40 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Dorsey M. D.

9-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Edward Bur

DATE OF BURIAL. 9/12/24

20-UNDERTAKER. Daniel Conlon

ADDRESS 916 Ba[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90187

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 666 Pabory St ST.: 7 WARD)

2-FULL NAME Richard E. Blackston Jr.

(a) RESIDENCE. No. 666 Pabory St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Dump wagon

(c) Name of employer M. Gerstle - Curtis Bay.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard E. Blackston

11 BIRTHPLACE OF FATHER (city or town) A. A. County (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Hammond

13 BIRTHPLACE OF MOTHER (city or town) A. A. County (State or country) Md.

14 Informant Richard E. Blackston

(Address) 666 Pabory St.

15 Filed SEP 12 1924 19 ROBERT R. KRAUTER, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1924, to Sept. 10, 1924, that I last saw him alive on Sept. 9, 1924, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy and Gastritis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. exam

(Signed) William C. Kame, M. D.

, 19 (Address) 1230 Penn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/12/24

20 UNDERTAKER Daniel Carbon ADDRESS 716 Penn

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1746 c D 90188

CERTIFICATE OF DEATH. X 100-00 D 90188

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME George Hudgins (Hudgins)

(a) RESIDENCE NO. Crisfield Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec 1st 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Ø

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews Co Va

PARENTS

10 NAME OF FATHER Louis Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Hudgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Hudgins

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEPT 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1924 to Sept 12th 1924, that I last saw him alive on Sept 12th, 1924 and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia bronchial

Terminal event

Urinary retention & extravasation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Crisfield Maryland

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Lee, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md

DATE OF BURIAL Sept 12 1924

UNDERTAKER Jno R A Elliott

ADDRESS 725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90189

CERTIFICATE OF DEATH.

D 90189

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Brevard St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mary Madden

(a) Residence No. 1000 Brevard St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jas J. Madden

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Owen Banaghan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Bridget Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Jas J. Madden

(Address) 1000 Brevard St

15-

SEP 12 1924

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9th, 1924, to Sept. 11th, 1924

that I last saw h. alive on Sept. 11th, 1924

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 2 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Georges E. Cross M. D.

, 19 (Address) 2409 Md. Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 9/13, 1924
Cathedral Cemetery	
20-UNDERTAKER, Chas. F. Kraus & Son	ADDRESS 16 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

D 90190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3810 Hamilton Ave ST., 24 WARD)

2-FULL NAME Awilda A. Brooks

(a) RESIDENCE No. 3810 Hamilton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, Widowed, ~~or Divorced, (write the word)~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus F. Brooks

6 DATE OF BIRTH (month, day, and year) Feb 9-1867

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hotopaxi Co Va

PARENTS

10 NAME OF FATHER Wm Rudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Augustus F. Brooks (Address) 3810 Hamilton Ave

15 SEP 12 1924 ROBERT E. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Sept 12, 1924.

that I last saw her alive on Sept 12, 1924

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fatty Degeneration of Heart

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic.

(Signed) Amory Worrell M. D.

, 19 (Address) 305 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hotopaxi Va	Sept 15 1924
20 UNDERTAKER	ADDRESS
Entrekin	1723 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

D 90191 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 49 D 90191

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Shafer

(a) RESIDENCE NO. 512 Shorb Ave ST., ... WARD .....
(Usual place of abode) Canton Ohio
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 8 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lizzie Shafer

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Construction work

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Monroe H. Shafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ruby Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) JOHNS HOPKINS HOSPITAL ROBERT A. KRAUTER

15 SEP 12 1924 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924, to Sept 11, 1924, that I last saw him alive on Sept 11, 1924, and that death occurred, on the date stated above, at 8:42 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma- Spinal cord

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? Yes Date of Sept 7-1924

Was there an autopsy? No

What test confirmed diagnosis? Path Exam.

(Signed) Warfield M. Firor M. D.

, 19 (Address) Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lebonon N.J.

DATE OF BURIAL 9/12/24 19

20 UNDERTAKER E. E. Hughes

ADDRESS 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 90192

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2722 Dillon St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Maliszewska

(a) Residence No. 2722 Dillon St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? 4 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 16-1923

7-AGE, 1 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Maliszewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Martha Skalenski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Joseph Maliszewski

(Address) 2722 Dillon St

15-

SEP 12 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 11th 1924 to Sept 11th 1924

that I last saw her alive on Sept 11th 1924

and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos 1+ ds.

CONTRIBUTORY (Secondary) Arthritis & heart failure

(Duration) yrs. mos. 1+ ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Symptom

(Signed) Jay A Smith M. D

, 19 (Address) 1628 E Baltimore.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem	Sep 13, 1924
20-UNDERTAKER,	ADDRESS
Stephen J Fiaikowski	1000 E Lemmon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90193

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 214 Arlington (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Henry

(a) RESIDENCE. No. 214 Arlington St. (Usual place of abode) St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28-1838

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 86

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 5 yrs ago

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Co. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jessie Henry

(Address) 214 N Arlington Ave

15 SEP 12 1924

ROBERT R. KRAUTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1924, to Sept 9, 1924, that I last saw h— alive on Sept 8, 1924, and that death occurred, on the date stated above, at 6a, m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Old Kidneys

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Symptoms

(Signed) Charles F. Gimbel M. D.

, 19 (Address) 212 S Thurston Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 12 1924
20 UNDERTAKER	ADDRESS
Samuel A Kemsley	1328 Edmondson Ave

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90194

CERTIFICATE OF DEATH.

160 D 90194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Ethel ST., 17 WARD)

2-FULL NAME Earlin Banks

(a) RESIDENCE No. 1330 Ethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-2-24

7 AGE Years Months Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Richard Banks

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Emma Beale 9-12-1924

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Richard Banks (Address) 1330 Ethel St

15 SEP 12 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1924

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows: Congenital Debility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. McKee, M. D.

(Address) Health Office Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Co DATE OF BURIAL Sept 14-24

20 UNDERTAKER Samuel Kemsley ADDRESS 1125 Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90195

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15 49

Registered No. D 90195

City of BALTIMORE: (No. 1629 Thomas ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Fogel

(a) Residence No. 1629 Thomas ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Fogel

6-DATE OF BIRTH (month, day and year)

7-AGE. 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Grocer

(b) General nature of industry, business, or establishment in which employed (or employer). Merchant

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Rafel Fogel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

11-

(Informant) Jack Lewis

(Address) 1429 E Balto St

Filed SEP 12 1924 19?. ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11-1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924, to Aug 11 1924,

that I last saw him alive on Aug 9 1924

and that death occurred, on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Lung

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. — X-ray

(Signed) Jacob Levin M. D.

9-11, 1924 (Address) 223 E Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Bonn Brandons Cem	Sept 13 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1429 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90196

CERTIFICATE OF DEATH

162 D 90196

1-PLACE OF DEATH Hebrew Hospital

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 1

2-FULL NAME Baby Udoff.

(a) RESIDENCE No. 2318 Jefferson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1924

7 AGE — Years — Months — Days — If LESS than 1 day, ~~7~~ hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry Udoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Pushkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Joel Rosenbl

Address [illegible]

15 Filed SEP 12 1924, 19 ROBERT B. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1924, to Sept. 11, 1924.

that I last saw h alive on Sept. 11, 1924.

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Death followed normal delivery after fetus presented normally.

..... (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Joseph Friedler M. D.

9/11, 19 24 (Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock Road

DATE OF BURIAL 9/12, 19 24

20 UNDERTAKER Rock Levin

ADDRESS 1709 Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

Fraser

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90197 (65-74)

CERTIFICATE OF DEATH. X 16-60 D 90197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Fraser

(a) RESIDENCE NO. Lawrence Point ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Fraser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Koroleff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records, JOHNS HOPKINS HOSPITAL.

SEP 12 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Sept 11, 1924, that I last saw him alive on Sept 11, 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Am Jacobsen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, DATE OF BURIAL Sept. 13-1924

20 UNDERTAKER M. J. Sadowski. ADDRESS 905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 90198

CERTIFICATE OF DEATH.

1794

D 90198

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 S. Potomac ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Michael Kuczynski,

(a) RESIDENCE NO. 517 S. Potomac St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Briget Kuczynski,

6 DATE OF BIRTH (month, day, and year) August 17th.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	I	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER **** Kuczynski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mrs. Pauline Lutkowski, (Address) 517 S. Potomac St

15 SEP 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Sept 11, 1924

that I last saw him alive on Sept 10, 1924

and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

Oedema Lungs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) CA Leifschneider, M. D.

9/11, 1924 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Sept. 15. 1924.
20 UNDERTAKER	ADDRESS
M F. Sadowski.	905 S. Ann

Spec.—1-10-21—M&T—1500 Bks.

Hanson

D 90199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90199

CERTIFICATE OF DEATH.

X 91-005

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Mary Hanson

(a) RESIDENCE NO. Allanson W. Va ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word)

Female | White | Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. W. Hanson

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Christopher B.

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Adline Hanson

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant C. W. Hanson Relative
(Address) JOHNS HOPKINS HOSPITAL

15 Filed Sept 2 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Sept 1, 1924, that I last saw h.. alive on Aug 19, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Gangrene of right leg

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Senile
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Allanson W. Va

Did an operation precede death? Yes Date of Sept 1 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Study

(Signed) Geo. L. Blodgett M. D.

19 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allanson W. Va | DATE OF BURIAL 9/12 1924

20 UNDERTAKER Jack Lewis | ADDRESS 1439 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEPT 2 1924

Spec.—1-10-21—M&T—1500 Bks.

90200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D 90200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Light st ST., 24 WARD)

2-FULL NAME Richard George Eugene Bett

(a) RESIDENCE NO. 1317 Light st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33 yr.	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Drug Business

(c) Name of employer Harry F. Lindman

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wiley Bett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie Bett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Annie Bett.

(Address) 1317 Light st.

15 SEP 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924 to Sept. 10, 1924 that I last saw h[illegible] alive on Sept. 9, 1924 and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry Reed Clements M.D.

, 19 (Address) 933 Hearn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 9/13 1924

20 UNDERTAKER: J. F. Talley & Son — ADDRESS: 1318 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90201

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rev. Richard D Drake

(a) Residence No. Mt Hope Retreat St., 28th Ward Norfolk Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. abt 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Religious

(b) General nature of Industry, business, or establishment in which employed (or employer) Priest - 65

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14-

(Informant) Records of Mt Hope Retreat

(Address) Mt Hope Retreat

15-

Filed SEP 12 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11th 24

17- I HEREBY CERTIFY, That I attended deceased from March 4-24, 19..., to Sept 11 1924, 19...,

that I last saw h...alive on..., 19...,

and that death occurred, on the date stated above, at...m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

following Arteria Sclerosis

Sudden (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senile Psychosis

Abt (Duration) 1 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Norfolk Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

Sept 4th, 1924 (Address) Mount Hope

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Hawley Pa	9/13, 1924
20-UNDERTAKER.	ADDRESS
J. J. Haley Sons	318 Eighth St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90202

CERTIFICATE OF DEATH.

127 D 90202

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Sarah A. Lee

(a) RESIDENCE NO. Mercy Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Married. 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed ....., 19.... Robert P. Harrison, Registrar

P 1 3 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/24

17 I HEREBY CERTIFY, That I attended deceased from 9/4/24, 19...., to 9/12/24.

that I last saw h.. alive on 9/12/24 and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

.....(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Goldzier, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem | DATE OF BURIAL 9/13/24

20 UNDERTAKER Campbell Finley Fulton & Smyth | ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90203

CERTIFICATE OF DEATH.

D 90203

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cassidy

(a) Residence No. 211 N. Caroline St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ Mary V. Cassidy

6-DATE OF BIRTH (month, day and year) Nov. 10th. 53

7-AGE.	If LESS than 1 day,
70 yrs. 10 mos. 2 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Buyer for

(b) General nature of industry, business, or establishment in which employed (or employer). Canning House

(c) Name of employer. J.L. Langrell & Co.

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Cassidy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Elizabeth Hulse

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14-

(Informant) Mary V. Cassidy

(Address) #211 N. Caroline St.

15-

Filed SEP 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 12/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1924 to Sept. 12 1924

that I last saw him alive on Sept. 12 1924

and that death occurred, on the date stated above, at 2.30 a. p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerbral Hemarrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Geo. B. Sybert M. D.

9/12. 1924 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	9/15 1924
20-UNDERTAKER, Philip Hemig	ADDRESS 2016 Orleans St.

USE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90204

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Cecil Saldomridge

(a) RESIDENCE No. 3413 Eastern ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1924

7 AGE — Years 1 Months 12 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Saldomridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Madeline Rafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant .....
(Address) .....

15 Robert P. Harrison, 19 .....
Registrar
Burial Permit Clerk.

P 1 3 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 12 - 1924, that I last saw him alive on Sept 12 - 1924 and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and vomiting

(duration) yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund Kemper, M. D.
7/12, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 13, 1924

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St

WARNING—REGISTERED UNDER LAWS OF MARYLAND. P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90205 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 E Cross St., 24 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W Sank

(a) Residence No. 110 E Cross St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 10 1865

7-AGE. 59 yrs. 4 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore City

PARENTS:

10-NAME OF FATHER David V Sank

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth F Fielding

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) George A Sank

(Address) 110 E Cross St

15- Filed 1924 Robert P. Harrison, Registrar.

EP1 3 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1924 to Sept 11 1924

that I last saw h in alive on Sept 11 1924

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H Harrison Lee M. D.

Sept 12 1924 (Address) 4 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park DATE OF BURIAL. Sept 13 1924

20-UNDERTAKER John F Denny ADDRESS 715 Lexington St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90206

CERTIFICATE OF DEATH.

D 90206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Vincent ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Thomas.

(a) RESIDENCE. NO. 1418 Vincent ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Thomas.

6 DATE OF BIRTH (month, day, and year) Aug. 20 1842.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	82	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lillian Brown

(Address) 1403 Argyle Ave.

Filed SEPT 3 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 11, 1924, that I last saw her alive on Sept 10, 1924, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

Sept 11 1924. (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Sept 14 1924
20 UNDERTAKER	ADDRESS
I. H. Brown & Son	1087 N. Mont

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90207

CERTIFICATE OF DEATH.

D 90207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2334 N. Gilmor ST.) (14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Pines

(a) RESIDENCE. No. 2334 N. Gilmor ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Pines

6 DATE OF BIRTH (month, day, and year) Sept 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER William Brandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Viola Sampler

(Address) 2347 N. Gilmor st

15 Filed SEP 13 1924. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I attended deceased from August, 1924, to Sept 11, 1924, that I last saw her alive on Sept 10, 1924, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemmorhage

(duration) ... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

Sept 12, 1924 (Signed) A. H. Fontaine, M. D.

(Address) 1123 Druid Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 14 1924
20 UNDERTAKER	ADDRESS
J. L. Bruce & Son	1617 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90208

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 90208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Sam. Wiggins

(a) Residence No. 823 Warner st. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clacy Wiggins

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Nick Wiggins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Alice white

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed SEP 13 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1924 to Sept. 10 1924

that I last saw h. im alive on Sept. 10 1924

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Pulmonary tuberculosis

Lues

(Duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure with pulmonary edema (Duration) Uncertain yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Schon M. D.

Sept. 10, 24 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 12 - 1924

20-UNDERTAKER.	ADDRESS
S. E. Brown & Son	1811 W. Mound-st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90209

90 90209

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 W. Lombard ST. 76 WARD)

2-FULL NAME Charles Brown

(a) RESIDENCE NO. 2544 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859 June 2nd

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Main

PARENTS

10 NAME OF FATHER Christian Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) White Haven Pa

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lucy A. Brown

(Address) 2544 W. Lombard St

15 Filed SEP 13 1924, 19.. Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to Sept 11th, 1924,

that I last saw him alive on Sept 11th, 1924

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. D. Lightner M. D.

9/12/24 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem — DATE OF BURIAL Sept 13 1924

20 UNDERTAKER Robert Brookerson — ADDRESS Calhoun Hoffman st

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and undertakers CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90210

CERTIFICATE OF DEATH.

12/22-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 450 Lorraine Ave St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Minnie B. Sullivan

(a) Residence No.....450 Lorraine Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Daniel D. Sullivan

6-DATE OF BIRTH (month, day and year) Jan. 28 1864

7-AGE, 60 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Leopold Blumenberg

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Amelia Krone

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant)... D. D. Sullivan

(Address)..450 Lorraine Ave

15-

Filed SEP 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEP 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 20, 19 24, to ~~that~~ Sept 12, 19 24

that I last saw h.. alive on Sept 12, 19 24

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Hepatic Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~~no~~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~no~~

(Signed) D. W. Paddock, M. D.

SEP 13 1924 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, Parkwood DATE OF BURIAL, SEP 15 1924, 19....

20-UNDERTAKER, Geo W Little ADDRESS 2708 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Information required. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90211

CERTIFICATE OF DEATH.

D 90211

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Keller

(a) RESIDENCE NO. Morgantown W Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. W. Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 13 1924 19 ..... Registrar

Burial Permits Clerk

Robert P. Hartman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1924 to Sept 12 1924, that I last saw him alive on Sept 12 1924 and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy, Benign.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis.

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Morgantown, W. Va.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Winfield W. Scott M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgantown W Va — DATE OF BURIAL Sept 13 19 24

20 UNDERTAKER Joseph Adams — ADDRESS 220 Bway

662

EP 1

READ.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90212

1-PLACE OF DEATH Pronounced Dead at 3 REGISTERED NO.

CITY OF BALTIMORE: (No. St Joseph Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Michael

(a) RESIDENCE NO 2308 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Michael

6 DATE OF BIRTH (month, day, and year) Jan 8th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Wm Michael (Address) 2308 Baker

Filed SEP 19 1924, 192 Robert P. Harrison, Registrar

Burial Permits Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) hrs. mos. ds.

(Signed) James M Fenton, M. D.
(Coroner.)

Sept 13, 1924 (Address) 700 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Sept 14 1924
20 UNDERTAKER	ADDRESS
H. Gander & Sons	918 Fleet

GPO.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6845 Broadway ST., 8 WARD)

REGISTERED NO. 1295

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Miller

(a) RESIDENCE NO 1523 N Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 22 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	86	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Shipbuilder
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Maryann Bliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Miller
(Address) 1523 N Broadway

15 Filed SEP 13 1924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds.

(Signed) James M Fenlon, M. D.
(Coroner.)

Sept 13 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept 13 1924
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BINDING

SEP 13 1924

ROBERT F. MARTIN
ASSIST. BURIAL PERMIT CLERK

Spec.—1-10-21—M&T—1500 Bks.

D 90214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90214

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph William Gibson, Jr.

(a) RESIDENCE NO. 621 Gutman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	8	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph William Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Maggie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant University Hospital Records.

(Address)

15 Robert T. Marriott. 19

SEP 13 1924 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1924, to Sept 10, 1924, that I last saw h alive on Sept 10, 1924, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

(a) Cancrum oris (noma)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Sept 8, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept 10 1924
20 UNDERTAKER Harry W. Elden	ADDRESS 1944 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90215

CERTIFICATE OF DEATH.

D 90215

1-PLACE OF DEATH

City of BALTIMORE: (No.) Belmont Hotel St., 27 74-60 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth H. Ferguson

(a) Residence Belmont Hotel Warlington Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret Ferguson

6-DATE OF BIRTH (month, day and year) Sept 11 1850

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 845

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), India

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) Robert N. Hanna

(Address) 2122 Madison Ave

15- Filed SEP 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924 to Sept 11 1924

that I last saw h. alive on Sept 11 1924

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy, with Cerebral Haemorrhage + Complete Paralysis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Nephritis + Hypertension Blood Pressure yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. W. Mills M. D.

, 19 (Address) 6242 Cor 14 Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL, Sept 13, 1924

20-UNDERTAKER John O. Mitchell

ADDRESS 1201 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90216

CERTIFICATE OF DEATH.

1484 90216

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Pahtuvelle

(a) RESIDENCE NO. 724 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Frank Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hosp. Records.

15 Filed SEP 13 1924, 19 Robert F. Duffy Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Sept 11, 1924,

that I last saw her alive on Sept 11 19 24

and that death occurred, on the date stated above, at 4:25 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Gonococcus Infection

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pelvic cellulitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) I. B. Whaley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: Sept 14 1924

20 UNDERTAKER: Jerkler & Jerkler — ADDRESS: 1739 Eager

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90217

CERTIFICATE OF DEATH.

122-5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3513 O'Donnell ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Dronnmelhansen

(a) RESIDENCE NO. 3513 O'Donnell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ludwig H Dronnmelhansen.

6 DATE OF BIRTH (month, day, and year) August 10-1846.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	78	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work home-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Mrs Hattie Peetz

(Address) 3513 O'Donnell St.

15 Filed SEP 13 1924, 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1— , 1924, to Sept 10 , 1924, that I last saw her alive on Sept 9— , 1924, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic cirrhosis of Liver

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Riland, M. D.

9-11- 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Sept 13 1924
20 UNDERTAKER Zurkler & Zurkler	ADDRESS 1734 Eager

WARNING—REGISTRATION LAW REQUIRES THAT THIS CERTIFICATE BE FILED WITHIN 24 HOURS AFTER DEATH. PENALTY FOR NEGLECT.

B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. All questions should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 13 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90218

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Audry Turco

(a) Residence No. 2662 W. North Ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Apr 12, 1913

7-AGE. 11 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Turco

11-BIRTHPLACE OF FATHER (city or town) (State or Country). New York

12-MAIDEN NAME OF MOTHER, Anna Teague

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

11- (Informant) James Turco

(Address) 2662 W North Ave

12- 13 1924 Robert P. Harrison,

19 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 12th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 11th 1924 to Sept 12th 1924, that I last saw her alive on Sept 12th 1924, and that death occurred, on the date stated above, at 5.15A m.

The CAUSE OF DEATH* was as follows:

Tetanus Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of 9/11/24

Was there an autopsy? yes

What test confirmed diagnosis? Examination of gans.

(Signed) J. B. E. Deegan, M. D

, 19 (Address) 904 N Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Sept 15, 1924
20-UNDERTAKER	ADDRESS
J. D. Cook	502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Blks.

D 90219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90219

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1460 Reynolds St. 24 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Schwanke

(a) RESIDENCE. No. 1460 Reynolds St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Henrson

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Wm Schwanke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Schwanke
(Address) 1460 Reynolds St

15 Filed SEP 13 1924, 19 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25 , 1924, to Sept 12 , 1924, that I last saw h[illegible] alive on Sept 11 , 1924, and that death occurred, on the date stated above, at 6 20A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Late

(Signed) Wm E Stigler, M. D.

9/12, 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Louis	Sept 15 1924
20 UNDERTAKER W M Cook	ADDRESS 502 E Baltimore

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 90220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Fairmont ave W ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarette Elizabeth Ward

(a) RESIDENCE No. 1523 Fairmont ave W ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16, 1910

7 AGE — Years: 13 — Months: 8 — Days: 26 — If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard A. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Jaugusta Co Va

12 MAIDEN NAME OF MOTHER: Violet Thom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co Md

14 Informant: Violet Ward

(Address) 1523 W Fairmont Ave

15 EP 1 31924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 11, 1924, that I last saw h.. alive on Sept 11, 1924, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Stab Wound

Bilateral

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home 2 hours

Did an operation precede death? Date of

Was there an autopsy? Physical Exam

What test confirmed diagnosis?

(Signed) Walter J. Porter, M. D.

9-12 1924 (Address) 6100 Main

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Hubern — DATE OF BURIAL: Sept 13 1924

20 UNDERTAKER: Sam'l R. Fraser Sr — ADDRESS: 1400 Mosher

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90221

D 90221

147697

X113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gillian

(a) RESIDENCE NO. 707 E. St Sparrows Pt. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Plummer Gillian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Lash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL.

15 SEP 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 7, 1924, to Sept 11, 1924, that I last saw him alive on Sept 11, 1924, and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) Vomiting

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edward W. Keiper, M. D.

9/12, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury

DATE OF BURIAL: 9-13-1924

UNDERTAKER: Sam N. Chase Hse

ADDRESS: 1400 Mad

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item is important. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90222

CERTIFICATE OF DEATH.

69 D 90222

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Eastern Av. ST.; 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Viola Kane

(Residence in Baltimore: No. 2034 Eastern ave St.; ..... yrs., 5 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. March 19, 1924. (Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Kane

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Cecelia May Bishop

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Kane

(Address) 2034 Eastern Av

15-

Filed..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

SEP 13 1924

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 11, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1924, to Sept 11 1924, that I saw h.r alive on Sept 9 1924, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

..... (Duration) ..... yrs. 1 mos. 15 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alfred A. Brodbeck M. D.

Sept 11 1924 (Address) 8 E Pattison Pkwy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Sept. 13th 1924

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90223

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Duncan ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy F. Dunn

(a) RESIDENCE. No. 230 S. Duncan ST., 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., If of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John L. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Marie Dunn

(Address) 230 S. Duncan St.

Filed SEP 13 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12th 1924

17A I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924 to Sept 12, 1924

that I last saw h[illegible] alive on Sept 12, 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Enter-Colitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J. Jennings M. D.

9/12 1924 (Address) 1004 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	Sept. 13 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90224

CERTIFICATE OF DEATH.

46 D 90224

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1647 E. Eager St., St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Katherine Tucker.

(a) Residence No. 1647 E Eager St., St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank Tucker.

6-DATE OF BIRTH (month, day and year) Jan. 19, 1844

7-AGE, 80 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Wurtemburg Germany

PARENTS.

10-NAME OF FATHER, Christian Frack

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wurtemburg Germany

12-MAIDEN NAME OF MOTHER, Frack

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant)..... Mrs B K Tucker

(Address)..... 1647 E Eager St

15-Filed SEP 13 1924 1924 Robert P. Harrison, Registrar.

Burial Permit Died

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 12 1924

17-I HEREBY CERTIFY, That I attended deceased from August 4 - 24 to September 12 - 24, 19..., that I last saw h.. alive on September 12 - 24, 19..., and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & appendages

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Advanced age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris H. A. McCoy, M. D.

9/12, 1924 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem. DATE OF BURIAL, 12, 1924.

20-UNDERTAKER, J. Berman ADDRESS 1241 Bway.

IMP.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90225

CERTIFICATE OF DEATH.

161-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N Edew ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 707 N Edew ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/4/24

7 AGE — Years — Months — Days 9 — If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work non

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER [illegible] Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hazel Brown (Address) 707 N Edew st

15 Robert P. Harrison, ... 19.... Registrar

Burial Permit Clerk

P 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10 .1924. to Sept 12 .1924.

that I last saw him alive on Sept 11 .1924.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth and Malnutrition

(duration) since birth yrs. mos ds.

CONTRIBUTORY (Secondary) Unable to swallow

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R G Young M. D.

Sept 12, 1924 (Address) 1 Holy Comforter Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL 9/13/1924

20 UNDERTAKER H C Good 1405 McCulloh — ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 90226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87 D 90226

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N. Broadway ST., ... WARD)

2-FULL NAME Arthur Emmons

(a) RESIDENCE No. 1801 N. Broadway ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 12/18/1918

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
5	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Arthur O. Emmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Mary Hunickhouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Arthur Emmons
(Address) 1801 N. Broadway

15 SEP 13 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Sept. 11, 1924, that I last saw him alive on Sept 11, 1924, and that death occurred, on the date stated above, at 11 22 a. m.

The CAUSE OF DEATH* was as follows:

Pancreatitis Acute Hemorrhagic

(duration) yrs. ..... mos 1 ds. 4

CONTRIBUTORY (Secondary) Acute Broncho pneumonia

Diabetes (duration) yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) D. Schneider M. D.

9/12/1924 (Address) 3303 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 9/13 1924

20 UNDERTAKER George J. Ruth per A.H.

ADDRESS 173 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

John. Blaszak

D 90227

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 90227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Bank St ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Blaszek

(a) RESIDENCE NO. 1816 Bank ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Benedict. Blaszak

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Mary. Orlowski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr Benedict. Blaszak

(Address) 1816 Bank. Street

15 Date SEP 13 1924, 19 ... Robert P. Harriell, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 , 1924 , to Sept. 13 , 1924.

that I last saw him alive on Sept. 12 , 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

..... (duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) /

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Alice Anna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Sep. 15 1924

20 UNDERTAKER John A Weber ADDRESS 1803 Bank St

MARGIN RESERVED FOR BINDING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1800 (Correction made (See Letter on file Oct 1 - 1924 from W J Watson M.D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90228

CERTIFICATE OF DEATH.

89 D 90228

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 N Calvert ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aloysius F Connolly

(a) RESIDENCE NO. 2212 N Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER ~~Michael McCaffrey~~ Aloysius F Connolly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hook

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Edmund McCaffrey (Address) Baltimore Md

15 ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk

SEP 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Sept 12, 1924, that I last saw him alive on Sept 11, 1924, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm J Watson, M. D.

Sept 13 1924 (Address) 2128 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 15 1924
20 UNDERTAKER	ADDRESS
Henry H Jenkins Sons	Eichard McCollah &

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND REGISTRATION

Spec.—1-10-21—M&T—1500 Bks.

D 90229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90229

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 2 WARD)

2-FULL NAME Riordan L. Jackson

(a) RESIDENCE NO. 902 Lawrence St., El Paso, Texas
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 5 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Dec. 12, 1907

7 AGE — Years: 16 — Months: 8 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER: R. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Pat Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Parents
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 13 1924 ... 19 Robert P. Garrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924, to Sept. 13, 1924, that I last saw him alive on Sept 13, 1924, and that death occurred, on the date stated above, at 5:50 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus -

(duration) 16 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of Sept 12-24

Was there an autopsy? Yes

What test confirmed diagnosis? Exam.

(Signed) Warfield M. Firor, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: El Paso Texas — DATE OF BURIAL: 9/13 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Burg

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90230

CERTIFICATE OF DEATH.

D 90230

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eleanore Fitze

(a) Residence No. 2616 E. Preston St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 20/1919

7-AGE. 5 yrs. 21 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Fitze

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Cath. Arnold

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

11- (Informant) Cath. Arnold Fitze

(Address) 2616 E. Preston

15- FILED SEP 4 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1924 to Sept. 12, 1924

that I last saw her alive on Sept. 12 1924

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic ulcerative endocarditis (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Geo. B. Sybert, M. D.

9/12, 1924 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cem. DATE OF BURIAL. Sept. 15, 1924

20-UNDERTAKER. Jos. J. Harrison ADDRESS 1564 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90231

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N. Milton ST., 6 WARD)

2-FULL NAME Margaret V. Doelger

(a) RESIDENCE NO. 4 N. Milton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
about 75				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Thomas Nash

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Unger

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Estella Statter (Address) 4 N. Milton

SEP 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924, to Sept 12, 1924 that I last saw her alive on Sept 12, 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism.

1½ hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B O'Kelly, M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept. 15 1924

20 UNDERTAKER Jos. J. Mon — ADDRESS 156 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90232

CERTIFICATE OF DEATH.

1924 D 90232
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude E. Tuckerman (Stern)

(a) RESIDENCE No. 605 N Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Stern

6 DATE OF BIRTH (month, day, and year) Nov. 18 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hose mfr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER George A Tochterman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cath. Herr

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Geo. A. Tochterman
(Address) 605 N. Glover

Filed SEP 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Homicide
Gun Shot Wound of Chest
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

(Signed) Geo Clinton Pollitt M. D.
(Coroner.)
Sept 10 1924 (Address) 1453 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Sept. 15 1924
20 UNDERTAKER Jos. J. Herr ADDRESS 156 N. Liberty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Erlow Peltzer

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 90233

CERTIFICATE OF DEATH. X 84 D 90233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Erlow Peltzer

(a) RESIDENCE No. Reisterstown, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1904

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Peltzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Laura Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Evelyn Peltzer

(Address) Reisterstown Md.

15 Filed SEP 14 1924 RUBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1924, to Sept 12, 1924, that I last saw her alive on Sept 12, 1924, and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Apt 2 cerebellum (Edema)

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Respiratory paralysis

(duration) yrs. mos. 15 Min ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 11, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Swope M. D.

, 19 (Address) M S Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cemetery DATE OF BURIAL Sept 14 1924

20 UNDERTAKER Watts & Mc J. F. Edwin ADDRESS Reisterstown Md

WARNING—THIS SPACE RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90234

CERTIFICATE OF DEATH.

113 D 90234

1-PLACE OF DEATH Hebrew Hospital

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 3 WARD)

2-FULL NAME Baby Kaufman

(a) RESIDENCE No. 242 South Eden ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. 5 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1924

7 AGE — Years | Months 5 | Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Israel Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Eggin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14
Informant .....
(Address) .....

Filed SEP 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13 1924

17
I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to September 13, 1924, that I last saw h.. alive on September 13, 1924, and that death occurred, on the date stated above, at 12.22 a. m.

The CAUSE OF DEATH* was as follows:

Cachexia

(duration) — yrs. 4 mos 2 ds.

CONTRIBUTORY (Secondary) Diarrhea & Marasmus
(Chronic or constitutional conditions) — yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clin & Laboratory

(Signed) Isidor L. Jury M. D.

Sept 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL 9/16 1924

20 UNDERTAKER Levi 1409 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

Leah Dublin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90235

CERTIFICATE OF DEATH.

18-003

D 90235

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15 WARD)

2-FULL NAME Leah Dublin

(a) RESIDENCE No. 1641 Bentalou ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Dublin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Leon Nirosta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lily Sosta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) .....

15 SEP 1 4 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D.
(Coroner.)

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herzog Rm	Sept 14 192 4
20 UNDERTAKER Jack Lauber 1439	ADDRESS Bleak

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-2-24 [illegible] 400 Bks.

D 90236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 90236

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 316 S Duncan St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Anna E Peterson

(a) Residence No. 316 S Duncan St., 1st Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 62 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ WIFE of George H Peterson

6-DATE OF BIRTH (month, day and year) Mar 1862

7-AGE, 62 yrs. 6 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)... at Home

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mr Geo H Peterson

(Address) 316 S Duncan St

15- SEP 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11 1924

17- I HEREBY CERTIFY, That I attended deceased from ~~Sept 29~~ aug 1924, to Sept 11, 1924,

that I last saw h~~e~~r alive on Sept 8 1924

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

6 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) O S Freer, M. D.

9/12/24 (Address) 408 Eutaw Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Sept 14 1924

20-UNDERTAKER, Peter Nicolaus 2060 — ADDRESS Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90237

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 90237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE; (No. 2009 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Crawford

(a) Residence No. 2009 Bank St., 2 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of. George Crawford

6-DATE OF BIRTH (month, day and year) Aug 2nd 1865

7-AGE, 59 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Fred Kahler

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Clara Cradle

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mr Geo Crawford

(Address) 2008 Bank St

15-

SEP 14 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug- 23, 1924, to Sept 13- 1924,

that I last saw h~~er~~ alive on Sept 12 1924

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) ...yrs. 3 Wks - ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ...yrs. ...mos. 10 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

, 19 (Address) 125 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Sept 16, 1924

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90238 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3022 Guilford Ave. WARD) 17

2-FULL NAME Kate Isabella Toner

(a) RESIDENCE NO. 3022 Guilford Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. 6 ds. How long in U. S., if of foreign birth? 66 yrs. — mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of John M. Toner

6 DATE OF BIRTH (month, day, and year) Sept. 6. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Carling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Liz Pickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Ida Carling

(Address) 902 N Paul St

15

SEP 14 1924

ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from May, 1919, to Sept 12, 1924,

that I last saw her alive on Sept 11, 1924,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Pulmonary Edema)

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Wyken. Dustentown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem

DATE OF BURIAL Sept 15 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1402 W. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90239

CERTIFICATE OF DEATH.

D 90239 REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ... ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Crook

(a) RESIDENCE NO. 1726 Reynolds ST., WARD Front St. Md.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs Crook

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	49	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Thomas Crook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Addie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 14 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Sept 13, 1924.

that I last saw h— alive on Sept 13, 1924.

and that death occurred, on the date stated above, at 4:25 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Mediastinum

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) J. H. Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a. a Co	Sept 17 1924
20 UNDERTAKER Wm Cook	ADDRESS 501 E Wood

Spec—12-23-21—E.B.R.S.—400 Bks.

Seal

D 90240 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 163 D 90240

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 Woodyear St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lee

(a) Residence No. 927 Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If ~~married~~ widowed, ~~or divorced~~ ~~HUSBAND of (or)~~ WIFE of Silas Lee

6-DATE OF BIRTH (month, day and year) Oct. 30 1871

7-AGE 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Virgil Coleman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Fan Smith.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-(Informant) Jane Lucille

(Address) 927 Woodyear St

SEP 14 1924 ROBERT R. KRAUER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11, 1924.

17- I HEREBY CERTIFY, That I attended deceased from [illegible] 19[illegible], to [illegible] 19[illegible]

that I last saw h[illegible] alive on [illegible] 19[illegible]

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

[illegible] Pneumonia

[illegible]

[illegible] (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible], M. D.

19[illegible] (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. [illegible] Lancaster Va. DATE OF BURIAL. 9/14/24 19[illegible]

20-UNDERTAKER. Durrel Earley ADDRESS 916 Ga ave

Mary's Point Lancaster Co. Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90241

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Blanche Huber

(a) RESIDENCE. No. Virginia St and Oakland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June - 17 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburgh
(State or country) Pa.

PARENTS

10 NAME OF FATHER Matthias Huber

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Lorey

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sister M. Dionede
(Address) Notre Dame Virginia St. City

15 Filed SEP 14 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1924, to Sept 12, 1924, that I last saw her alive on Sept 11, 1924, and that death occurred, on the date stated above, at 11 - p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Endocarditis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Wm. R. Straight M. D.

9/13, 1924 (Address) 2036 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	Sept 15 1924
20 UNDERTAKER Frank A. Fink	ADDRESS 950 N. Gay

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ridl

D 90242

HEALTH DEPARTMENT—CITY OF BALTIMORE

123 D 90242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home And Infirmary

CITY OF BALTIMORE: (No. ..... ST., 27 WARD (Ridl)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Ridel

(a) RESIDENCE NO. 4618 Harford Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white american

5 Single, Married, Widowed, or Divorced. (write the word) ~~Widowed~~ Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Frank Ridel

6 DATE OF BIRTH (month, day, and year) Mar 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Jos. Vinack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Ridl

(Address) 4618 Harford Road

15 SEP 14 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924.

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Sept 12, 1924, that I last saw him alive on Sept 12, 1924, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis + cholecystitis, chr.
Bowel between gall bladder + stomach

(duration) not known yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of Aug 26 1924

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) K.E. Rice, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL 9/15 1924

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90243

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Geneva Apts. 3405 Greenway St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah Elizabeth Cochran

(a) Residence No. Geneva Apts. Greenway St., Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? 89 yrs. 4 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the Word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Cochran

6-DATE OF BIRTH (month, day and year) May-2-1835

7-AGE. 89 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer). None

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Wm. Amey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary Creamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Mr. L. B. Reeder (son-in-law)

(Address) 3405 Greenway

15- SEP 14 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13 1924

17- I HEREBY CERTIFY, That I attended deceased from July 17, 19 24, to Sept 13, 19 24

that I last saw h. alive on Sept 12, 19 24

and that death occurred, on the date stated above, at one o'clock a. m.

The CAUSE OF DEATH* was as follows:

Fracture of upper end of Left Femur.

(Duration) — yrs. one mos. 27 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. one ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sidney F. Tillman, M. D.

, 19 (Address) 6 E. Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Sept-15-24
20-UNDERTAKER,	**ADDRESS**
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AV.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECOR... should be carefully supplied. AGE should be stated E... in plain terms, so that it may be properly classified. ...very importa... ...ted. Exact statement of OCCUPA... ...fied. ...instructions on back of certificates.

DARK

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1742D490244

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Finkelstein

(a) RESIDENCE No. 2300 E. Baltimore / ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 22 1924

7 AGE: Years ..... Months ..... Days 1 month

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Isadore Finkelstein

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Esther Epstein

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 21 1924 to Sept 14 1924 that I last saw him alive on Sept 14 1924 and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Pyelitis, acute

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Diarrhea (not dysentery) Vomiting

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edmund H. Kerper M. D.

9/14, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Sept 14 1924

20 UNDERTAKER J. Lennon & Bro.

ADDRESS 727 E. Balto St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-203

REGISTERED NO. D 90245

1-PLACE OF DEATH Pronounced dead at St. Joseph Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis A. Denson

(a) RESIDENCE No. 1029 N. Bond St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13yrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 21/1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	5	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ambrose Denson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Princess Anne, Md

12 MAIDEN NAME OF MOTHER Frances Macurek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Frances Denson (mother)
(Address) 1029 N. Bond St

15 Filed SEP 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull &neck etc-run over by automobile.

(Inquest Sept 16/24

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J H Dalton, M. D. (Coroner.)

9/13/24, 192 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemty	Sept 16 1924
20 UNDERTAKER Robt F Turner & Son	ADDRESS 242 E. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 90246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 71-002 D 90246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 401 Sanders ST., (or) WARD)

2-FULL NAME Herman Charles Smith

(a) RESIDENCE NO. 401 Sanders ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 10/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Samuel Smith (Address) 401 Sanders

15 SEP 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13/24

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 24, to Sept 13/24,

that I last saw him alive on Sept 10/24,

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

Purulent

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Hall, M. D.

Sept 13/24 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 15 1924

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 90247

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 24 WARD)

2-FULL NAME Charles Gregory

(a) RESIDENCE NO. 1410 Belt Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb. 22 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Packing Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. R. Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital
(Address)

15 SEP 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia
(Rractured 4th cervical vertebra-accidental-fell down stairs at his home, Sept. 7/24)

Duration ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) C. W. Collins, M. D.
(Coroner.)

9/13/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Sept. 15 1924

20 UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 90248
1 PLACE OF DEATH

CERTIFICATE OF DEATH

6 90 REGISTERED No. D 90248

CITY OF BALTIMORE (No. 1824 Orleans St. 6 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ANNA HUCHENS

(Residence in Baltimore: No. 1824 Orleans St St.; 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Unknown (Month) (Day) (Year)

7 AGE: 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: ~~Unknown~~ Alex Perkins

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Nelson

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ch Huchens
(Address): 1824 Orleans

15

SEP 14 1924

ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 (Month) 12 (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~9-12~~ 191~~4~~ to 9-12 1914, that I saw h~~er~~ alive on 9-12 1914, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

about 1 hr Myo Carditis

(~~Duration~~) 1 yrs. mos. ds

Contributory (SECONDARY) Acute Nephritis

(Duration) yrs. mos. ds.

(Signed) J Frank M. D.

9-12 191~~4~~ (Address) 2739 W Eday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Bury cemetery — DATE OF BURIAL: Sept 16, 1914

20 UNDERTAKER: Edward Bryon — ADDRESS: 1631 Orleans

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 90248

CERTIFICATE OF DEATH

D 90248

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1824 Orleans 6 90 ST.: 6 WARD) REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ANNA HUCHENS

(Residence in Baltimore: No. 1824 Orleans St St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE C

5-~~SINGLE~~ MARRIED ~~WIDOW OR WIDOWED~~ (Write the word) Married

6-DATE OF BIRTH Unknown (Month) (Day) (Year)

7-AGE 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Housework (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Alex Wilkins ~~Unknown~~

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Mary Wilkins

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ph Huchens

(Address) 1824 Orleans

15

SEP 14 1924

ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 9 (Month) 12 (Day), 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~9-12~~ 1914, to 9-12 1914, that I saw h alive on 9-12 1914, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) J. D. Evans M. D.

9-12, 1914 (Address) 2939 W Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodberry cemetery

DATE OF BURIAL Sept 16, 1914

20-UNDERTAKER Edward Bryon

ADDRESS 1631 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90249 — 74-001 — D 90249

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md. Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Burke

(a) RESIDENCE. No. Easton, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year) Dec 2, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Centreville, Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Burke

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Meyers

13 BIRTHPLACE OF MOTHER (city or town) Wilmington
(State or country) Del

14 Informant W. B. Swezey.
(Address) Maryland Penitentiary

15 SEP 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Sept 13, 1924, that I last saw him alive on Sept 13, 1924, and that death occurred, on the date stated above, at 4:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John M. Edmunds, M. D.

, 19 (Address) Md Penitentiary Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	Sept 15 1924
20 UNDERTAKER	ADDRESS
E. LeRoy Stifflen	1255 North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Eks.

D 90250 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90250

CERTIFICATE OF DEATH. X 74001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 733 E 23rd st St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Barrick

(a) Residence No. 733 E 23rd st St., Ward Walkersville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Noah Barrick

6-DATE OF BIRTH (month, day and year) Sept 20 1845

7-AGE. 79 yrs. 11 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mrs. Earnest Shoemaker

(Address) 733 E 23rd st

SEP 14 1924 ROBERT A. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Sep 6 1924 to Sep 13 1924 that I last saw her alive on Sep 13 1924 and that death occurred, on the date stated above, at 10.05 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of left side

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) E. J. Bouchelle M. D.

, 19 (Address) 2104 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Walkersville Md DATE OF BURIAL, Sept 16, 1924

20-UNDERTAKER, E Le Roy Stiffler ADDRESS 125 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gerik

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13

D 90251

D 90251

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Harris Al ST., WARD)

2-FULL NAME Mary Gerik

(a) RESIDENCE NO. 937 Harris Al ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 8, 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Fastyn Gerik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zofia Gniazdowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Fastyn Gerik

(Address) 937 Harris Alley

SEP 14 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept 12, 1924, that I last saw h 2 alive on Sept 12, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia Collapse

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J. Russell M. D.

Sept 13 1924 (Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL 9-15 1924

20 UNDERTAKER Stephen J. Fialkowski

ADDRESS 1000 S. Kenwood Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90252 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90252

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Robert ST., 14 WARD)

2-FULL NAME Edna A. Boone

(a) RESIDENCE NO. 520 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of James Boone

6 DATE OF BIRTH (month, day, and year) June 25 1888

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
36	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Woodin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Beath Copeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John W. Goodin (Address) 520 Robert St

15 Filed SEP 14 1924 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/12, 1924, to 9/12, 1924, that I last saw her alive on 9/11, 1924, and that death occurred, on the date stated above, at 8:35 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Renal (duration) Age 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Jackson M. D.

9/12 1924 (Address) 808 N Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-14-24

20 UNDERTAKER Harland Holland ADDRESS 1636 Mad Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90253

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 703 N. Callington St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Hart

(a) Residence No. 703 N. Callington St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) aug 11/1923

7-AGE, ...yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James J Hart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Mary L. Burns

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

It- (Informant) James J Hart

(Address) 703 N. Callington

SEP 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1924, to Sept 13, 1924, that I last saw h. alive on Sept 12, 1924 and that death occurred, on the date stated above, at 2-30A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

.....(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

.....(Duration).....yrs.....mos. 1 ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

Sept 13, 1924 (Signed) C. H. Campbell M.D. (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, Sept 15 1924

20-UNDERTAKER, William G Schaeffer — ADDRESS 816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec., 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90254

CERTIFICATE OF DEATH.

90 D 90254

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 W. Montgomery St. 27 WARD)

2-FULL NAME Rudaelph N. Retowsky

(a) RESIDENCE. No. 1127 W. Montgomery ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Retowsky

6 DATE OF BIRTH (month, day, and year) Sept 24/1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Rudaelph Retowsky

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs E. Retowsky
(Address) 1127 W Montgomery

15 [illegible]

SEP 14 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept 11, 1924 that I last saw h[illegible] alive on Sept 11, 1924 and that death occurred, on the date stated above, at 1-10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinate
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. L. Campbell M. D.

Sept 12 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 15 1924

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover St

Spec—12-23-21—E.B.R.S.—400 Eks.

Pridgeon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90255

D 90255

CERTIFICATE OF DEATH.

8 113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1231 N Washington St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie M Pridgeon

(a) Residence No. 1231 N Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23

7-AGE, ...yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS

10-NAME OF FATHER, Wm Pridgeon

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER, Bessie Loeller

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country),

14- (Informant) Wm Pridgeon

(Address) 1231 N Washington

SEP 14 1924

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-13-24

17- I HEREBY CERTIFY, That I attended deceased from 9-13 1924 to 9-13 1924

that I last saw him alive on 9-13 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) yrs. 9 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis Consumption

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dawe Miller M. D.

, 19 (Address) 1500 N Bdway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer Cem DATE OF BURIAL, 9/15, 24

20-UNDERTAKER, John Lucas ADDRESS 2008 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90256

CERTIFICATE OF DEATH.

D 90256

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1825 Clifton Avenue St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Wesley Yienger

(a) Residence No..... 1825 Clifton Avenue St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr. 22nd, 1924

7-AGE, ... yrs. 4 mos. 9 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph B. Yienger

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jeanette Kruemmel

13-BIRTHPLACE OF MOTHER (city or town) Lansdowne
(State or Country), Maryland

14- (Informant) Joseph B. Yienger
(Address) 1825 Clifton Avenue

15- SEP 14 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 2x, to Sept 13, 19 2x, that I last saw him alive on Sept 12, 19 2x, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas A. Schaefer, M. D.

9-13, 1924 (Address) 53 S. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
Laurel Hill Cem	Sept 15 2x
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bals

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90257 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 3 D 90257

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Butler

(a) RESIDENCE NO. Anne Arundel Co. Md. ST., WARD Edgewater Md

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1913

7 AGE: Years 11; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): a a Co and

PARENTS

10 NAME OF FATHER: Enoch Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): a a Co and

12 MAIDEN NAME OF MOTHER: Rosa Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): a a Co and

14 Informant: Enoch Butler

(Address) Edgewater and

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-14-1924

17 I HEREBY CERTIFY, That I attended deceased from 9-17-24. 19 to 9-14-24. 19, that I last saw her alive on 9-13-24 19, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Buckley Butler M. D.

, 19 (Address) 753 McCulloh St. Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marks Cemetery

DATE OF BURIAL: Sept 16 1924

20 UNDERTAKER: [illegible]

ADDRESS: Annapolis Md

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90258

181-B 90258

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Presbyterian Eye Ear Hosp (ST.) 18 (WARD)

2-FULL NAME Mozella Jones

(a) RESIDENCE NO. 318 N Appleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Ellis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Martha Jones
(Address) 318 N Appleton

15 Filed SEP 15 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Status Lymphaticus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Etherauarthesia accident
(duration) yrs. mos. ds.

(Signed) James M Easton, M. D.
(Coroner.)
Sept 14 192 4 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Point Wharf Va — DATE OF BURIAL 9/15/24

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa ave

Cor.—1-12-23—M&T—100 Bks.

D 90259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 Bayard St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Stalker

(a) RESIDENCE NO. 1234 Bayard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stalker

6 DATE OF BIRTH (month, day, and year) Jan 14 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) So. Carolina

PARENTS

10 NAME OF FATHER Cato Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Carolina

12 MAIDEN NAME OF MOTHER Lucy Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) So. Carolina

14 Informant Mary Walker (Address) 1234 Bayard St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to h.s death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 1 hours

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos B. Norton, M. D.

(Coroner.)

Sept 12 1924 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/15/24
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90260

CERTIFICATE OF DEATH.

D 90260

REGISTERED NO. 1197

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 13 WARD)

2-FULL NAME Mr. Hyman Goldman

(a) RESIDENCE No. 2015 Callow Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Goldman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Zalman Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed SEPT 5 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to Sept 14, 1924, that I last saw him alive on Sept 14, 1924, and that death occurred, on the date stated above, at 1:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Foulure

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Pancreas Appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes. Date of 9/12/24

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A. Adler Landsman, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 9/15 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90261

#7468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Martha Washington

(a) RESIDENCE NO. 1008 N. Carlton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 15 1924 ROBERT S. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924, to Sept 13, 1924, that I last saw her alive on Sept 13, 1924, and that death occurred, on the date stated above, at 8:10 a. m.

The CAUSE OF DEATH* was as follows:

Acute secondary pneumonia (broncho)

(post pertussis)

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund K Kepler, M. D.

9/14, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 15 1924

20 UNDERTAKER Sam'l E Rose & Son

ADDRESS 400 Mosher

Cor.—1-12-23—M&T—100 Bks.

D 90262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09

D 90262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland Dent Hos ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dellie Elizabeth Gladding

(a) RESIDENCE No 2923 Parkwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry T Gladding

6 DATE OF BIRTH (month, day, and year): Mar 5th 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co Va

PARENTS

10 NAME OF FATHER: George Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mr Harry T Gladding
(Address) 2923 Parkwood Ave

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)
Sept 12 1924 (Address) 2 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 15 1924
20 UNDERTAKER: Wm J Tinker & Sons	ADDRESS: Monck & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90263

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amy Baldwin

(a) RESIDENCE NO. 1203 N. Charles St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben L. Baldwin

6 DATE OF BIRTH (month, day, and year) April 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Sheldon Hollingsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Charlotte Entsminger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, , 1924, to Sept 11, , 1924, that I last saw h... alive on Sept 11, , 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Chronic Nephritis, Acute Cardiac Failure

Hard Times (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hard Times

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. H. Cramer M.D. M. D.

19-24 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Sept 15, 24

20 UNDERTAKER Wm Fickner Sons ADDRESS Norristown Pa

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90264

CERTIFICATE OF DEATH.

D 90264

1-PLACE OF DEATH Hospital for the Women of Maryland

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Lafayette & John Sts. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mildred Hortense Leland —

(a) RESIDENCE NO. 2608 Roslyn Ave. — Balto. ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	32	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James Withers Leland

11 BIRTHPLACE OF FATHER (city or town) Richmond Co. (State or country) Va.

12 MAIDEN NAME OF MOTHER Willie Ann Hixcum

13 BIRTHPLACE OF MOTHER (city or town) Northumberland Co. (State or country) Va.

14 Informant James W. Leland (Father) (Address) 2608 Roslyn Ave. Balto.

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1924, to Sept. 13, 1924.

that I last saw her alive on Sept. 13, 1924.

and that death occurred, on the date stated above, at 6.27 P m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

Intestinal Perforation

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? Yes Date of Sept. 6, 1924.

Was there an autopsy? No —

What test confirmed diagnosis? Phy. Exam. + Operation —

(Signed) J. Clyde Corfield, Jr. M. D.

19 (Address) Womans Hospital —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. | DATE OF BURIAL Sept 16 1924

20 UNDERTAKER Wm. J. Rudicill Sons | ADDRESS Northam

(over)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90265

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3714 North Road. Hallcrofts ST. ..... WARD)

2-FULL NAME Mary V. Metcalfe

(a) RESIDENCE No. 3714 North Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Thomas Metcalfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Kreig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thomas A. Myers

(Address) American Bldg

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1924 to Sept. 14, 1924, that I last saw her alive on Sept. 13, 1924, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with cerebral congestion, and resultant Paralysis. due to cerebral thrombosis (duration) yrs. ... mos 24 ds.

CONTRIBUTORY (Secondary) Age. and bad vitality (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Harley Dale, M. D.

9/14 1924 (Address) 2707 Fenwick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chambersburg Pa. DATE OF BURIAL Sept 16 1924

20 UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90266

CERTIFICATE OF DEATH.

162 D 90266

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway - ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Francis Hoffman.

(a) RESIDENCE No. 3923 Edmondson Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 0 mos. 0 ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-14-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank A.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Getrude Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant F. A. Hoffman

(Address) 3923 Edmondson Ave

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-14, 1924, to 9-14, 1924, that I last saw him alive on 9-14, 1924 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Extrauterine asphyxia.
- A few spasmodic respiratory acts - at irregular intervals until death.

(duration) yrs. 2 hours mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith C. Rice, M. D.

. 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet C.	9/15 19 24

20 UNDERTAKER Wm J. Fickus Sons

ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 90267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp WARD)

2-FULL NAME Mr Chas Trischman

(a) RESIDENCE NO. 512 N. Bond St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Pearl Trischman

6 DATE OF BIRTH (month, day, and year) Dec 11-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Just Trischman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Anna Winter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant (Address) Colonial Hospital North Mount St. Reard

15 Filed SEP 15 1924 ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 27th, 1924 to Sept. 13th, 1924.

that I last saw him alive on Sept 13, 1924.

and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cellulitis of Rt arm (duration) yrs. mos 21 ds.

18 Where was disease contracted if not at place of death? Division of Fuel.

Did an operation precede death? Yes Date of 8/27/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) AC Manninger, M. D.

Sept 15 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	9/16/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes,	424 N. Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

174 17 D 90268

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D 90268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Bleinberger

(a) RESIDENCE No. 2812 Riggs Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Bleinberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Minnie Kobsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1924 to Sept 13, 1924, that I last saw him alive on Sept 13 - , 1924, and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Hare-lip

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County.	Sept. 15 1924
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

Cor.—1-12-23—M&T—100 Bks.

D 90269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 129 D 90269

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L. Ritter.

(a) RESIDENCE NO. Levering House 100 N. Front St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Huckster.
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Ritter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Julia A. Watts.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Julia A. Burkman. (mother).
(Address) 1113 W. Cross St.

15 Filed SEP 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Kinnaedt, M. D. (Coroner.)

Sept. 13, 1924. (Address) 1019 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Levering House September 11. 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem. DATE OF BURIAL Sept 15th 1924

20 UNDERTAKER Jos Poerdens & Son ADDRESS 2175 Pa...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90270 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90270

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3915 Park Heights Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Rosa Rider

(a) Residence No. 3915 Park Heights Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced,
Female	White	~~Widow~~

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Moses Rider

6-DATE OF BIRTH (month, day and year) Nov. 14, 1851

7-AGE. 72 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER Samuel Sondheimer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Sylvan Rider

(Address) 3915 Pk. Heights Ave

15- Filed SEP 15 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/13/24.

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1924 to Sept 13, 1924 that I last saw h... alive on Sept 13, 1924 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis - chronic nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Fred Leitz M. D.

Sept 13, 1924 (Address) 2040 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Balto. Hebrew Cem.	9/15/, 1924
20-UNDERTAKER. David Sondheim	ADDRESS 117-20 No. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90271

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N Carlin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Henson

(a) RESIDENCE NO. 604 N Carlin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a if married, widowed, or divorced HUSBAND of (or) WIFE of: James Henson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: approx 60 Months: ~ Days: ~ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Peter Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Howard Henson (son)

(Address): 514 Fremont st

15 SEP 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 12, 1924, that I last saw him alive on Sept 12 1924, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Interstitial Nephritis and Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. H. Young, M. D.

9/13. 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion — DATE OF BURIAL: Sept 16 1924

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY; WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 90272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90272

CERTIFICATE OF DEATH.

REGISTERED NO. 312

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 Haw ST., 22 WARD)

2-FULL NAME Irene Sheppard

(a) RESIDENCE NO. 643 Haw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Arthur Sheppard

6 DATE OF BIRTH (month, day, and year) May 15, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	35	4	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER John Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Henriette Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Audrey Bannister (Address) 643 Haw St

15 Filed SEP 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sep. 3, 1924, to Sep 12, 1924, that I last saw h[illegible] alive on Sep 3, 1924, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. F. Howell, M. D.

(Address) 1129 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooks Chapel Cemetery Md

DATE OF BURIAL Sept 15 1924

20 UNDERTAKER Joseph A Farrell

ADDRESS 2318 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17D 90273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

GD 90273

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. Gertrude ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Hoffman

(a) RESIDENCE NO. 711 S. Second St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ( )

6 DATE OF BIRTH (month, day, and year) October

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
11 months				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 SEP 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1924, to Sept. 14, 1924, that I last saw h alive on Sept. 14, 1924, and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Acute secondary pneumonia (Bronchopneumonia)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Dysentery (Bacillary, midwifed)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund A Kemper, M. D.

9/15, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL 9-15 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90274 HEALTH DEPARTMENT—CITY OF BALTIMORE

179168

CERTIFICATE OF DEATH.

45 D 90274

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Wallace

(a) RESIDENCE NO. 811 Rutland Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Wallace

6 DATE OF BIRTH (month, day, and year) July 13 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45 yrs	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Lloyd Wallace

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Fannie Robinson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed Sept 19 24 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1924, to Sept. 13, 1924, that I last saw him alive on Sept. 13, 1924, and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch A&C	Sept 16 1924
20 UNDERTAKER John F Deasy	ADDRESS 715 Lex St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90275

CERTIFICATE OF DEATH.

113 D 90275

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 418 S. Wolfe St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleonra . Rozga

(a) Residence No. 418 S. Wolfe St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 26 1924

7-AGE. ....yrs. 1 mos. 19 ds. (If LESS than 1 day, ...hrs. or ....min.)

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Blatimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John. Rozga

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Anna. Wrzesinska

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

11- (Informant) Mr John. Rozga

(Address) 418 S. Wolfe Street

15- Filed ..... 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1924 to Sept. 14 1924

that I last saw h[er] alive on Sept. 13 1924

and that death occurred, on the date stated above, at 9 30a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ....yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) acidosis

(Duration) ....yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Centerville Md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) A F Ries M. D

(Address) Sept 15 1924 24 E Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Stanislaus	Sep. 15 1924

20-UNDERTAKER, John M Weber ADDRESS 1803 Bank st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90276

1-PLACE OF DEATH .

Registered No.....

City of BALTIMORE: (No.) 1815 Chilton ave St. (Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel T. Fritts

(a) Residence No. 1815 Chilton ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie R. Fritts

6-DATE OF BIRTH (month, day and year) March 18th 1863

7-AGE, 61 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Poultry Business
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William T. Fritts

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Dorathy Whittington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Calvert Co Md

14-
(Informant) Mrs Bessie K. Fritts
(Address) 1815 Chilton ave

15-
Filed SEPT 5 1924 192
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 13th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to Sep 13, 1924 that I last saw him alive on Sep 13, 1924 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.

4/14 19 24 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Sept 17th, 1924

20-UNDERTAKER, George S. Schilling & Sons — ADDRESS 1801 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90277

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2740 Fenwick ave St.: 9 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Taylor W. Thomas

(a) RESIDENCE. No. 2740 Fenwick ave St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie E. Thomas

6 DATE OF BIRTH (month, day, and year) July 14th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Md School for the Blind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah E Hurl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Annie E Thomas

(Address): 2740 Fenwick ave

15 SEP 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to Sept 12, 1924, that I last saw h.. alive on Sept 12, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Geo. L. Zimmerman M. D.

9/12, 1924 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 16th 1924

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 E Monument St

RESERVED FOR BINDING

PLEASE WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90278 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 100-001 D 90278

1-PLACE OF DEATH Boyle's Hospital Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grongaist, Jacob

(a) Residence No. 720 N. Broadway St., Ward

(Usual place of abode) Infirmary (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1882

7-AGE 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Boyle's New Hospital

(Address) Baltimore, Md.

15- Filed SEPT 5 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-11-24

17- I HEREBY CERTIFY, That I attended deceased from 9/8/ 1924 to 9/11/ 1924 that I last saw him alive on 9/10/ 1924 and that death occurred, on the date stated above, at 12:40 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Alcoholic Delirium

? (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes Lab. & clinical findings.

What test confirmed diagnosis?

(Signed) H. F. Eckard M. D.

9/13/ 1924 (Address) Boyle's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bethlehem DATE OF BURIAL. , 19

20-UNDERTAKER. ADDRESS

Lilly & Zeiler 403 S. Wolfe St

1765

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 90279

CERTIFICATE OF DEATH.

49 D 90279

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 E 30th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M Martin

(Residence in Baltimore: No. 1930 E. 30th St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 3, 1857
(Month) (Day) (Year)

7-AGE, 67 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George H Darsey.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret A Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Martin

(Address) 1930 E 30th St

15-

SEP 15 1924 1924 .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 17 1924, to Sept 13 1924, that I saw her alive on Sept 13 1924, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

a. Carcinoma of the Bladder

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Fisher M. D.

9/17/24 101 (Address) 1823 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, 9/16/1924

20-UNDERTAKER E. D. Fanning & Son

ADDRESS 1938 E. Lafayette Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90280

CERTIFICATE OF DEATH.

D 90280

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 411 E. Hamburg St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME...Melvin L. Airey.

(a) Residence No. 411 E. Hamburg St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced. (Write the word.): Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ~~March, 25, 1924.~~

7-AGE, ...yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Olla Airey.

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary E. Breeden.

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14-

(Informant) Mary Airey.

(Address) 411 E. Hamburg St.

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9.14.24

17- I HEREBY CERTIFY, That I attended deceased from 9.11, 1924, to 9.14, 1924, that I last saw him alive on 9.14, 1924, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Gen. Intoxitions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) L. F. Turlington, M. D.

9.14, 1924 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. | DATE OF BURIAL: Sept. 16, 1924

20-UNDERTAKER: A. Howard Evans | ADDRESS: 38 E Fort Ave.

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raymond + Dulaney aves — ST., 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Andrew Charles Spencer -

(a) RESIDENCE NO. West minster md - ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m ale

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married.

6 DATE OF BIRTH (month, day, and year)

7 AGE 61 Years 10 Months 4 Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer -

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer owne farm.

9 BIRTHPLACE (city or town) (State or country) West Minsty Md.

PARENTS

10 NAME OF FATHER Mr David Spencer.

11 BIRTHPLACE OF FATHER (city or town) West-minster (State or country) md -

12 MAIDEN NAME OF MOTHER Mrs cathrine Burns.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mr David spencer. (son)
(Address)

Filed SEP 15 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Sept 15, 1924, that I last saw him alive on Sept 15, 1924, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Of descending Colon - Metastases To Liver -

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? yes Date of Aug 28 1924

Was there an autopsy? yes -

What test confirmed diagnosis? autopsy

(Signed) C. R. Monroe, M. D.

, 19 (Address) West Baltimore General Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dear Park Cemetery

DATE OF BURIAL Sept. 17 1924

20 UNDERTAKER James M. Strevig

ADDRESS Westminster Md

Spec.—1-10-21—M&T—1500 Bks.

D 90282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90282

CERTIFICATE OF DEATH.

X 101

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert and 33rd ST.) 17 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Genevieve Morris

(a) RESIDENCE No. 9 East Lafayette Ave ST. WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 mos ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 28. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 0

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Belair, Maryland.

PARENTS

10 NAME OF FATHER Joseph Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Findley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. G. Morris 9 E. Lafayette Ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14. 1924

17

I HEREBY CERTIFY, That I attended deceased from August 7. 1924, to September 14, 1924, that I last saw h e v alive on Sept. 14. 1924 and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Cert Lower Lobar Pneumonia

..... (duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) M. D. Walsh, M. D.

Sept 14 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harford Co. Md. Rock Spring Cemetery

DATE OF BURIAL Sept 16 1924

20 UNDERTAKER Chas. E. Homberger

ADDRESS Benson Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90283 ✓

D 90283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Raymond Capozzi

(a) RESIDENCE NO. 723 S. Decker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Child mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Dan Capozzi

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Franadydowsky

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Parents
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 15 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1924, to Sept 12, 1924,

that I last saw him alive on Sept 12, 1924,

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute secondary pneumonia (Broncho)
(Bd pertussis)

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Diarrhea (not dysentery) and Vomiting

(duration) ..... yrs. ..... mos. 2 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund A Kemper, M. D.

9/17, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Trappe Rd — DATE OF BURIAL: Sept 15 1924

20 UNDERTAKER: Wendell Dippel Inc — ADDRESS: 37 S Amity St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1743 D 90284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90234

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., V WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Hager

(a) RESIDENCE NO. 113 S Durham St., ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Live mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Elmer Hager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Koller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 15 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 19 -, 1924, to Sept 14, 1924,
that I last saw her alive on Sept 14 -, 1924,
and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & vomiting

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Furunculosis

(duration) ..... yrs. ..... mos. 17 ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter E. Stewart M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 16 1924

20 UNDERTAKER: Wendell Zippelson — ADDRESS: 375 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90285

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2638 Frederick Ave St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine L. Klein

(a) Residence No. 2638 Frederick Ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Henry Klein

6-DATE OF BIRTH (month, day and year) July 17, 1882

7-AGE. 42 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Theodore A. Kirby

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Joanna A. O'Gorman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant). Henry Klein

(Address). 2638 Frederick Ave

15- Filed....., 19..... Robert P. Harrison, Registrar.

P 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to Sept 14, 1924, that I last saw h~~er~~ alive on Sept 13, 1924, and that death occurred, on the date stated above, at 7.25 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) M. O'Neill, M. D.

9/15, 1924 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Sept. 17, 1924

20-UNDERTAKER. George J. Smith — ADDRESS 1532 Hollins

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90286

CERTIFICATE OF DEATH.

D 90286

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Carter

(a) Residence No. 228 S. Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jack Carter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192.... Registrar.

SEP 15 1924

Burial Permit No. 1768

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-10-24

17- I HEREBY CERTIFY, That I attended deceased from 8-23 1924 to 9-10 1924

that I last saw him alive on 9-10 1924

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aneurysm of Thoracic Aorta; Myocardial degeneration (Duration) yrs. 3 mos. (History)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. + X-ray

(Signed) Claude C. Heard M. D.

9-11 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Robert P. Harrison, Commissioner of Health;

ADDRESS

SEP 13 1924

Per. Wm. E. McCall

UNIVERSITY OF MARYLAND

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK.

Cor.—1-12-23—M&T—100 Bks.

D 90287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90287

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 844 S Bond ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ferrin Lopez

(a) RESIDENCE NO 844 S. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lopez

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

886

9 BIRTHPLACE (city or town) Chile
(State or country)

PARENTS

10 NAME OF FATHER Lopez

11 BIRTHPLACE OF FATHER (city or town) Chile
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Chile
(State or country)

14 Informant Police Dept
(Address) Eastern Sta

15 Filed SEP 15 1924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Kenlon, M. D.
(Coroner.)
Sept 12 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	192
20 UNDERTAKER	ADDRESS
Commissioner Health	SEP 19 1924

Robert T. Harrison, Burial Permit Clerk.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90288

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 327 N Pratt ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Moore

(a) RESIDENCE NO 327 N Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 55				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 009
(c) Name of employer Don't Know

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant Robert P. Harrison
(Address)

15 Filed SEP 15 1924 Burial Permit Issued
Registrar

THE MORGUE. 1766

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Heart disease

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) ....(Coroner.), M. D.

, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND.

Commissioner Health,

Per. Wm. E. Woodall

SEP 15 1924

(Instructions on back of certificate. See instructions on back of certificate.)

Cor.—1-12-23—M&T—100 Bks.

D 90289

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 90289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found Harbor Foot of Eden St

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(a) RESIDENCE No ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Police Dept
(Address) Eastern Sta

Filed SEP 15 1924

Robert P. Harrison, Registrar

Chief Deputy Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hunter M. D.
(Coroner)
....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 192

20 UNDERTAKER Commissioner Hoods

ADDRESS .....

Dep. Wm. E. Woodall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90290

CERTIFICATE OF DEATH.

182 D 90290

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. found at East Falls & Fleet St. ST., 3 WARD)

2-FULL NAME.....

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 887
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) unknown

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Police Department
(Address) Custom House

Filed SEP 15 1924, 192.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Gibson, M. D.
(Coroner.)

Sept 12 192 4 (Address) 788 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. DATE OF BURIAL 192

20 UNDERTAKER Robert P. Harrison, ADDRESS .....
Robert P. Harrison
Public Funeral Director

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90291

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 W. Fayette ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brady.

(a) RESIDENCE No. 742 W Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1/2 hr.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Denard Brady

11 BIRTHPLACE OF FATHER (city or town) Cape Charles Va (State or country)

12 MAIDEN NAME OF MOTHER Gladys Penny

13 BIRTHPLACE OF MOTHER (city or town) Newport News Va (State or country)

14 Informant Denard Brady (Address) JOHNS HOPKINS HOSPITAL

15 ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17

I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....,

that I last saw h— alive on Sept 1, 19 24,

and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Stone M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19.....

20 UNDERTAKER Commissioner Health.

Per Wm. E. WOODALL

ADDRESS

SEP 15 1924

SEP 15 1924

1772

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

REGISTERED NO. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Heckert

(a) RESIDENCE No. 619 Warner ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? 56 yrs. 9 mos. 13 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Heckert

6 DATE OF BIRTH (month, day, and year) Feb 10, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Altenbrück (Hanover) Germany

PARENTS

10 NAME OF FATHER Nicholas Fiedemann

11 BIRTHPLACE OF FATHER (city or town) Altenbrück (State or country) (Hanover) Germany

12 MAIDEN NAME OF MOTHER Mary Hinke

13 BIRTHPLACE OF MOTHER (city or town) Altenbrück (State or country) (Hanover) Germany

14 Informant Henry Fiedemann

(Address) 4 Echodale ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 24, to Sept 14, 19 24, that I last saw her alive on Sept 14, 19 24, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Epithelioma of face

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Edwards, M. D.

....., 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Sept 16, 19 24

20 UNDERTAKER Mrs. John W. Teufel & Son

ADDRESS 801 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert P. Harrison, Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 90293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90293

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harry E. Ramsey

(a) RESIDENCE NO. 282 Lincoln Ave ST., Rockville Centre, Long Island. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit grower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Harry E Ramsey

(Address) 282 Lincoln Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12, 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 24, to Sept 12, 19 24, that I last saw him alive on Sept 12, 19 24, and that death occurred, on the date stated above, at 2 00 P m.

The CAUSE OF DEATH* was as follows:

Chr. cholecystitis: abdominal adhesions.

Carcinoma of transverse colon

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Post-operative shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 11, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Fitzpatrick, M. D.

, 19 (Address) 11 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middlebury Falls Vt. DATE OF BURIAL: Sept 16 19 24

20 UNDERTAKER: Harry H. Witzke ADDRESS: 1521 W. Lombard

EP 15 1924

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 90294

CERTIFICATE OF DEATH

129 D 90294

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1325 N Stricker ST. WARD) 15

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Fowlkes

(Residence in Baltimore: No. 1325 N Stricker St. 22 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colored	Married

6 DATE OF BIRTH Unknown (Month) (Day), 1879 (Year)

7 AGE 45 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9 BIRTHPLACE (State or country) Crew Va

PARENTS

10 NAME OF FATHER Campbell James

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George B Fowlkes

(Address) 1326 N. Stricker St.

15 Filed SEP 15 1924, 191 ... Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 13 (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept. 13 1924 that I saw h[illegible] alive on Sept. 12, 1924 and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. 12 ds

Contributory (SECONDARY) Apoplexy

(Duration) yrs. ... mos. 1 ds.

(Signed) Irene Edwards M. D.

Sept 15 1924, 191 ... (Address) 710 N Mt Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL Crew Virginia — DATE OF BURIAL Sept. 14, 1924

20 UNDERTAKER Mrs. James H. Dennis — ADDRESS 1303 Presstman

Spec.—1-10-21—M&T—1500 Bks.

D 90295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90295

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 19 WARD)

2-FULL NAME Gladys Henson

(a) RESIDENCE No. 304 W. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Noah Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1924, to Sept. 14, 1924, that I last saw her alive on Sept 14, 1924, and that death occurred, on the date stated above, at 10 40 A. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos. 1 wk

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Sept 16 1924

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90296

1-PLACE OF DEATH

City of BALTIMORE: (No. 924 N. Eden Street St., 10 90 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Tierney

(a) Residence No. 924 N. Eden Street St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Tierney

6-DATE OF BIRTH (month, day and year) 9/25/1884

7-AGE. 39 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) for City.

(c) Name of employer.....

040

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Michael Tierney

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth Doertie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Annie Tierney

(Address) 924 N. Eden Street.

15- Filed SEP 15 1924 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEP 13 1924

17- I HEREBY CERTIFY, That I attended deceased from APR 22 1924 19.... to SEP 13 1924 19....

that I last saw him alive on SEP 13 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 9/9 yrs. 4 mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Duker M. D.

SEP 15 1924 (Address) 928 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	9/16/....., 19 24
20-UNDERTAKER. George J Ruth Per D.A.	ADDRESS 1735 HARFORD ave.

P 15 1924

IN ITS PERMANENT RECORDS. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Dr Morrissey

D 90297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 18

CITY OF BALTIMORE: (No. ____ ST., 12 WARD)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles T. A. Fountain

(a) RESIDENCE No 102 West 26th ST., ____ WARD ____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) Sept 2, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	—	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Vernon Fountain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester Penna

12 MAIDEN NAME OF MOTHER Lucy T Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salt Lake City Utah

14 Informant Vernon Fountain
(Address) 102 West 26th Street

15 Filed ____, 192 ____ Robert P. Harrison, Registrar
Burial Permit Clerk.

SEP 15 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Fractured Skull Injuries by falling out of bed accidentally

(duration) ____ yrs. ____ mos ____ ds.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ (Coroner.), M. D.

Sept 12, 1924 (Address) 5032 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Sept 17 192 4
20 UNDERTAKER W. M. Cook	ADDRESS 502 E Northern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90298

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Banks

(a) Residence No. 500 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 11 1859

7-AGE. 66 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Lewis Banks

11-BIRTHPLACE OF FATHER (city or town) Ellicott City (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth A White

13-BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or Country), Md

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 9 1924 Robert P. Harrison, Registrar.

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-14-24

17- I HEREBY CERTIFY, That I attended deceased from 9-2, 1924 to 9-14, 1924 that I last saw him alive on 9-14, 1924 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension;
Chronic Myocarditis; Myocardial
degeneration

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Dixon M. D.

9-15, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet	Sept 16, 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E North Ave

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wm P. Wilhelm ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90299 — 90 — D 90299

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4154 Bel Air Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Wm. P. Wilhelm

(a) RESIDENCE NO. 4154 Bel Air Road ST., 27th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of ~~only Wife of~~ Rebecca Feldman (deceased)

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1838.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 6/12 fr

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Germany
(State or country)

PARENTS

10 NAME OF FATHER Frederick A. Wilhelm

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant ..... Frederick A. Wilhelm.
(Address) 4154 Bel Air Road, Baltimore, Md.

15 FILED SEP 15 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept. 2, , 19 24 , to Sept. 14, , 19 24 ,

that I last saw h... alive on Sept. 14, , 19 24 ,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

Aortic Insufficiency

(duration) One year yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No , Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. L. Wilkinson , M. D.

, 19 (Address) 23 W. Bel Air Road, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Harford Rd	Sept 17 1924
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Lennie 4706 Harford Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90300

CERTIFICATE OF DEATH.

46

D 90300

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 West Lanvale ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Casey

(a) RESIDENCE NO. 1319 West Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Casey

6 DATE OF BIRTH (month, day, and year) Oct 13 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	70	11	2	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Snow Hill Maryland

PARENTS

10 NAME OF FATHER Beach Conard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary C. Stidham

(Address) 1319 West Lanvale

15 Robert P. Harrison, Registrar

P 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Sept 15, 1924, that I last saw h alive on Sept 14, 1924 and that death occurred, on the date stated above, at 4 A 716 m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus with metastasis to pelvis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Simons, M. D.

Sept 15, 1924 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Oliver Cemetery	Sept 19
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 832 Pierce St., 18 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harriet Conway

(a) Residence No. 832 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Conway

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laundress

(b) General nature of industry, business, or establishment in which employed (or employer). At home

(c) Name of employer.

9-BIRTHPLACE (city or town). Orsana

(State or Country). Essex Co., Va

PARENTS.

10-NAME OF FATHER. Samuel Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Essex Co., Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant). Mrs. Anna Gibson

(Address). 832 Pierce St.

15- Filed Sept 5 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 14, 1924

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924 to Sept 14, 1924

that I last saw h[illegible] alive on Sept 14, 1924

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Cardiac

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 753 Lang St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bowers Wharf, Essex Co. Va.

DATE OF BURIAL. Sept. 17, 1924.

20-UNDERTAKER. Mrs. Kate R. Williams

ADDRESS 322 N. Schroeder St.

IMPORTANT: WHITE PLAINLY WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90302

CERTIFICATE OF DEATH.

90 D 90302

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 S Durham St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Lovell

(a) Residence No. 719 S Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. L. Lovell

6-DATE OF BIRTH (month, day and year) Aug. 1870

7-AGE, 54 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, August Baer

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Siebenberg

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14- (Informant) Wm. L. Lovell
(Address) 719 S. Durham St.

15- Filed SEP 16 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. Sept 13/24

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from 8/2, 1924 to 9/13, 1924

that I last saw h[er] alive on 9/13/24, 1924

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel E Pinkard, M. D.

, 1924 (Address) 332 S Paca

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cem	Sept 16, 1924
20-UNDERTAKER.	ADDRESS.
H. Sauder Sons	1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90303

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 539 W. West St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Davis

(a) Residence No. 539 W. West St.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-Single, Married, Widowed or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1888

7-AGE: 36 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0/10

(c) Name of employer: .....

9-BIRTHPLACE (City or town) (State or Country): Bell Ala

PARENTS.

10-NAME OF FATHER: W. Davis

11-BIRTHPLACE OF FATHER (City or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Henrietta Davis (widow)

13-BIRTHPLACE OF MOTHER (City or town) (State or Country): Md.

14-(Informant): Rosie Allen

(Address): 539 W. West St

SEP 16 1924

Filed ..... 192 ROBERT R. KRAUTH Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9/13/24

17-I HEREBY CERTIFY, That I attended deceased from May ..., 19 24 to Sept 13 ..., 19 24

that I last saw h.. alive on Sept 13 ..., 19 24

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ... yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. D. Bruce, M. D.

, 19 (Address) 1 W. Mt. Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL, 9/16/24

20-UNDERTAKER: Daniel Easton | ADDRESS 4 E Pleasant

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 90304

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 251 S. Madeira St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Vogel

(a) Residence No. 251 S. Madeira St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of ~~WIFE~~ Bernice Vogel Dec'd.

6-DATE OF BIRTH (month, day and year) April 21st 1875

7-AGE. 49 yrs. 4 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Inspector at 26

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Can Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, John G. Vogel Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Katherine Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Frank Vogel (Brother)

(Address) 251 S. Madeira St.

15- SEP 16 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 13th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 19 24 to Sept 13 19 24

that I last saw him alive on Sept. 13 19 24

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Heart & Hemorrhage

(Duration) 2 yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) 7 yrs. X mos. 1 ds.

18-Where was disease contracted if not at place of death? Dam

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Dam

(Signed) Jas. L. Dunn M. D.

(Address) 348 S. Ann St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wells Lawn Cem. — DATE OF BURIAL. Sept. 17 1924

20-UNDERTAKER, Lilly & Zeiler — ADDRESS 403 S. Wolfe St

NAME—Entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90385
173

HEALTH DEPARTMENT—CITY OF BALTIMORE 90305

CERTIFICATE OF DEATH.

65-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Milner

(a) RESIDENCE NO. 720 Pine St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Milner

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

886

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Daniel Milner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Jane Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22 - 1924, to Sept 13 - 1924, that I last saw him alive on Sept 13 - 1924, and that death occurred, on the date stated above, at 12 35 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Myeloid Leukaemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jacksonville Fla.	Sept 16 1924

20 UNDERTAKER Samuel F. Kennedy Co. ADDRESS [illegible] Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

90306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 513 N. Pine St. 17 Ward) 128

Registered No.....

2-FULL NAME.... Philip Campbell

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.... 513 N. Pine St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE~~ of Sarah Campbell

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Stephen Campbell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Caroline Tompro

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mamie Lewellyn

(Address) 513 Pine St.

15- Filed SEP 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 13 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Sept 13, 1924, that I last saw h.. alive on Sept 13, 1924, and that death occurred, on the date stated above, at 6.30 m. The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Edwin E. Wilson, M. D.

Sept 16, 1924 (Address) 156 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Port Auburn Cem. DATE OF BURIAL, Sept 16, 1924

20-UNDERTAKER, Edmund Kemsley ADDRESS 1 Baldwin

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X185 D 90307

1-PLACE OF DEATH S/S Corehatta.

CITY OF BALTIMORE: (No. Pier 6 Locust Point. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Parham. (C)

(a) RESIDENCE No. Melvale Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ---- mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (~~WIFE of~~) Frances Parham. (C)

6 DATE OF BIRTH (month, day, and year) December, 27, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Maryland Stevedoring Co.

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Robert Parham. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Louise Robinson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Frances Parham. (C) wife (Address) Melvale, Md.

15 Filed SEP 16 1924, 192 ROBERT B. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Accidental fall into the hold of S/S Corehatta.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Albert Reinhardt M. D. (Coroner.)

Sept. 15, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

(C)

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Sept 16 24
20 UNDERTAKER Chas. J. Hensley	ADDRESS Biddle

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90308

CERTIFICATE OF DEATH.

185 D 90308

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO GEN HOSP ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JAMES H. GARRETT

(a) RESIDENCE NO. 260 CEDAR ST WESTPORT ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Lanra Garrett

6 DATE OF BIRTH (month, day, and year) Nov 7 18[illegible]4

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69 ~~72~~	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gateman

(b) General nature of industry, business, or establishment in which employed (or employer) Rail Road, B & O

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James H Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Anna L Crouch

(Address) 3205 Colgate St

15 Filed SEP 16 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEPT 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from SEPT 10, 1924, to SEPT 13, 1924

that I last saw h./M. alive on SEPT 13, 1924

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

FRACTURE, RIGHT FEMUR, RIGHT RADIUS + TWO META CARPALS FROM A FALL (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) SHOCK (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? X-RAY, SIGNS & SYMPTOMS

(Signed) J E Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Sept 16 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

Accidental Fall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90309

CERTIFICATE OF DEATH.

123 D 90309

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1748 Homestead ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka Woodley

(a) RESIDENCE NO. 1748 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Woodley

6 DATE OF BIRTH (month, day, and year) Sept 16, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Warthan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter Hacker

(Address) 1748 Homestead St

15 Rec. SEP 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to Sept 13, 1924, that I last saw her alive on Sept 13, 1924, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Acute Indigestion & Gallstone

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Indigestion & Gallstone

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C P Carman, M. D.

9-15 1924 (Address) 1701 N Carolina ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto — DATE OF BURIAL Sept 16 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

24 D 90310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Greene & Redwood Sts

CITY OF BALTIMORE: (No. On Street in Auto ST., 7 WARD)

2-FULL NAME Sol I. Solomonson

(a) RESIDENCE NO. 2635 Madison av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Gans Solomon

6 DATE OF BIRTH (month, day, and year) March 21 / 87

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 04-3
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Herman Solomon

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Isbell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Gans
(Address) 2635 Madison ave

15 Filed SEP 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Duration

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D.
(Coroner.)

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cemetery	Sept 17 1924
20 UNDERTAKER J. Ahrens & Co	ADDRESS 1611 Madison Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90311 HEALTH DEPARTMENT—CITY OF BALTIMORE B 90311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9th W Fairfield ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Middleton

(a) RESIDENCE NO. 9th St Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 23 1924

7 AGE	Months	Days	If LESS than 1 day, hrs. or min.
7 mos			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Bernard Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Pearl Jones Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Pearl H. Ford

15 Filed SEP 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1924 to Sept 15 1924 that I last saw him alive on Sept 14, 1924 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. / mos. 15 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 15-W. J. Coleman, M. D.

(Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cet	Sept 17 1924
20 UNDERTAKER	ADDRESS
J D Brown & Son	108 N Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90312

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 90312

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1207 E. Chase St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary E. Ricker

(a) Residence No.... 1207 E Chase St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/24/1875

7-AGE, 49 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Peter H. May

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Elizabeth Powers

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Balto

14- (Informant) Rudolph J. Ricks

(Address) 1207 E Chase

15- SEP 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/14/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 19 24 to Sept 14 19 24

that I last saw h[illegible] alive on Sept 14 19 24

and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

9/15, 1924 (Signed) A. H. Thomsteen M. D.

(Address) 733 August Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross Cem — DATE OF BURIAL, Sept 17 19 24

20-UNDERTAKER, John Merrick — ADDRESS 2905 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90313

CERTIFICATE OF DEATH.

X 100-001 D 90313

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Beauchamp

(a) RESIDENCE NO. 92 2nd st. ST., Crisfield Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo D Beauchamp

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE: Years 31 | Months ? | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Chrisfield Md

PARENTS

10 NAME OF FATHER: George Beauchamp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Dora Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 SEP 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Sept 15, 1924, that I last saw h... alive on Sept 15, 1924, and that death occurred, on the date stated above, at 1025 A.M.

The CAUSE OF DEATH* was as follows:

Thrombocytopenic purpura

Chronic Pneumonia

Pericarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) × Pneumonia

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Crisfield Md.

Did an operation precede death? ..... Date of ..... Aug 15th

Was there an autopsy? Yes Pathological Purpura

What test confirmed diagnosis?

(Signed) Winfield Wyatt, M. D.

, 19 (Address) Johns Hopkins H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chrisfield Md — DATE OF BURIAL Sept 16 1924

20 UNDERTAKER: John Ellis — ADDRESS 2008 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1418 West Franklin St., 19 Ward) 57

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harvey

(a) Residence No. 1418 West Franklin St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (write word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Harvey

6-DATE OF BIRTH (month, day and year) May 23rd. 1859

7-AGE,	If LESS than 1 day,
65 yrs. 3 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Thomas E. Conley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Rebecca Pitcher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Charles W. Harvey

(Address) 1418 W. Franklin St

SEPT 6 1924 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 19 20, to Sept 14, 19 24, that I last saw h... alive on Sept 14, 19 24, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Pitcher M. D.

9-14 19 24 (Address) 1601 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lowden Park Cem	Sept 17, 19 24
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1053 N. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 341 S. Monroe Street St. 19 Ward) 31

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Eva L. Smardon

(a) Residence No.....341 S. Monroe Street.....St.,.....Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 9, 1906

7-AGE. 17 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Presser

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Grant U. Smardon

11-BIRTHPLACE OF FATHER (city or town).....Anne Arundel Co.
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Catherine A. Grace

13-BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or Country), Maryland

14-

(Informant).....George J. Smardon

(Address).....341 S. Monroe Street

15-

SEP 16 1924 ROBERT A. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 21, 19 24, to Sept. 14, 19 24

that I last saw h.. alive on Sept. 14, 19 24,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tubercular Meningitis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan M. D.

9-15-, 19 24 (Address) 24 N Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem	Sept 18, 1924
20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 W Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90316 / 1734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D 90316

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Heckman

(a) RESIDENCE No. 1612 Belleview Ave ST., WARD Catonsville Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 8, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Heckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margie Ve Dale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed SEP 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to Sept 15, 1924, that I last saw h[illegible] alive on Sept 15, 1924, and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) A. Sweany, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Md	9/16/24
20 UNDERTAKER W. J. Tickner and Sons	ADDRESS Pikesville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5102 Wilson Ave ST. 27 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie V. Hand

(a) RESIDENCE No. 5102 Wilson Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William R. Hand.

6 DATE OF BIRTH (month, day, and year) July 1, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER ? Perrine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Wm. L. Jenkins

(Address) 113 Eckerdale Ave.

15 SEP 16 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19 , 1920 , to Sept 15 , 1924.

that I last saw her alive on Sept 15 , 1924

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos 1/12 ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. A. Hemmeter, M. D.

Sept 16, 1924 (Address) 7002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Sept 17 1924

20 UNDERTAKER W. J. Richardson Sons

ADDRESS North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of ... PA-

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90318 ✓ D 90318

D 90318
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. 129

City of BALTIMORE: (No. 1366 N Stricker St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Burley

(a) Residence No. 1366 N Stricker St St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widow Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Louis Burley

6-DATE OF BIRTH (month, day and year) Sept 12 1871

7-AGE. 53 yrs. Sept 12 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Henry Jones.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-(Informant) Mrs S Howard
(Address) 1366 N Stricker St

15-Filed 192 Registrar.
Robert P. Harrison,
~~Burial Permit Clerk~~

P 1 6 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 15/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1924, to Sept 15 1924 that I last saw h[illegible] alive on Sept 15 1924 and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

9/16, 1924 (Signed) H S McCard M. D
(Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lemon A.C. | DATE OF BURIAL Sept 17th 1924

20-UNDERTAKER. Lemmon & Wright | ADDRESS 1364 N Carey St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 90319

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 8 WARD)

2-FULL NAME Margaret Mooney

(a) RESIDENCE NO. 154 Ellwood Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 66

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER J. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Hospital Record
(Address)

15 Filed ..... 19.... Robert P. Harrison Registrar

EP 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/24

17 I HEREBY CERTIFY, That I attended deceased from 9/12/24, 19...., to 9/16/24, 19....,
that I last saw her alive on 9/16/24, 19....
and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? San Agnes Hospital

Did an operation precede death? Yes Date of 7/3/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) R. W. Holden M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interbaltimore Cathedral Bom | DATE OF BURIAL 9/17 1924

20 UNDERTAKER J. G. Kroan | ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90320

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1225 McCulloh St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard L. Gray

(a) Residence No. 1225 McCulloh St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 29 ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Webster

6-DATE OF BIRTH (month, day and year) Feb. 17, 1851

7-AGE. 73 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Beef Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Richmond Market

(c) Name of employer: 013

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Richard L. Gray

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Ann -----

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Mrs. Mary Webster

(Address) 1225 McCulloh St.

15- [illegible] 10[illegible] Robert P. Barrier Registrar.

SEP 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.20 to Sept. 16 19.24,

that I last saw him alive on Sept. 15 19.24,

and that death occurred, on the date stated above, at 5:20 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Roof of mouth

Heart. Gland of neck.

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Calvarian Carcinoma

& Lungs (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? ? E1923

Did an operation precede death? Yes Date of 1920-1922

Was there an autopsy? No

What test confirmed diagnosis? Examination of tissues

(Signed) Glenn S. Bishop, M. D.

. 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Druid Ridge Cemetery	9/18 19.24
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90321

D 90321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1762 E. Northave St., 8 Ward) 47 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Corpreew

(a) Residence No. 1762 E. Northave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 10, 1870

7-AGE. 54 yrs. 7 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) Sand Kirk & Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thos Corpreew

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Susanah Morgan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Mida Corpreew

(Address) 1762 E. Northave

15- Filed 1924 Robert P. Harrison Registrar.

EP 16 1924

Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924 to Sept 16, 1924 that I last saw her alive on Sept 16, 1924 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. C. Burnbaugh M.D.

9-16, 1924 (Address) 1531 E. Northave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore	Sept 19 1924
20-UNDERTAKER, Zurkler & Zurkler	ADDRESS 1734 Eager st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90322

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 864 St Peter St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Moxley

(a) Residence No..... 864 St Peter St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 27 1923

7-AGE, ... yrs. 11 mos. 19 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, George Moxley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Mary Wurster

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs. Mary Moxley

(Address) 864 St Peter st

15- Filed ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

P 1 6 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 15, 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Sept 15 1924

that I last saw h.. alive on Sept 15, 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed) R. P. Campbell, M. D.

16, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Sept 17, 1924

20-UNDERTAKER, James Di'gnan & Son — ADDRESS 1000 S Paca st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-081 ✓ D 90323

D 90323

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 23 E. 21 st ST. 17 WARD)

2-FULL NAME Ella Sherwood Blake

(a) RESIDENCE NO. 23 E. 21 st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. R. Blake

6 DATE OF BIRTH (month, day, and year): Jan. 11. 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Kern Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co. Md

12 MAIDEN NAME OF MOTHER: Sarah J. Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mr. Geo. R. Blake 23 E. 25th St.

15 Filed SEP 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 20, to Sept 14, 19 24,

that I last saw her alive on Sept 14, 19 24, and that death occurred, on the date stated above, at 9 58 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ——

(Signed) Geo. H. Forsythe M. D.

9/16/1924 (Address) 2435 Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. DATE OF BURIAL: Sept 17 1924

20 UNDERTAKER: Wm Tucker & Sons ADDRESS: Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lubeck Mt Emmett 23 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Bensinger

(a) RESIDENCE No. 419 W West St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Bensinger

6 DATE OF BIRTH (month, day, and year) [illegible] 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER David Bensinger

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md

14 Informant Geo. Bensinger
(Address) 419 W West St

15 Filed SEP 16 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner.), M. D.

, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	9-17- 1924
20 UNDERTAKER Robert Brooks & Son	ADDRESS Calhoun Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90325

CERTIFICATE OF DEATH.

113 D 90325

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 E York ST. 27 WARD)

2-FULL NAME Grace M. Bell

(a) RESIDENCE NO. 5 E. York ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John F. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Kreitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Bell

(Address) 5 York St.

15 Filed ..... 19..... Registrar

SEP 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1924, to Sept 16th, 1924.

that I last saw her alive on Sept 16th, 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea & enteritis

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) — yrs. — mos. 1 hour

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Weibel M.D.

Sept 18 1924 (Address) 1024 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loters Bulb Co	Sept 18 1924
20 UNDERTAKER CRENOWETH & SON	ADDRESS
3617 CHESTNUT AVE	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 2 V D 90326

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Kernan Hospital St. 26 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nathan Francis Comer

(Residence in Baltimore: No. Brunswick Md St.; ..... yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 29, 1922 (Day) (Year)

7 AGE: 4 yrs. 2 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Brunswick, Md.

PARENTS

10 NAME OF FATHER: Emory Francis Comer

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Rachael H. Good

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emory F Comer

(Address) Brunswick Md

Filed SEP 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 16, 1924 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924, to Sept 16 1924 that I saw h[illegible] alive on Sept 16, 1924 and that death occurred, on the date stated above, at 5.30 P. m.
The CAUSE OF DEATH* was as follows:

Paralysis of Respiratory Centre

(Duration) ..... yrs. ..... mos. 5. ds

Contributory (SECONDARY) Cerebro Poliomyelitis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Wilson N Dameron M. D.

Sept 16, 1924 (Address) 1104 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Brunswick Md — DATE OF BURIAL: Sept 17, 1924

20 UNDERTAKER: C. H. Zile & Son — ADDRESS: Brunswick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

Cancehl.

D 90327 HEALTH DEPARTMENT—CITY OF BALTIMORE R 90327

90

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mt Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Canehl.

(a) Residence No. Mt Hope Retreat St., U.K. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1844

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)..... Blacksmith
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant)..... Mt Hope Friends
(Address)..... Mt Hope Md

SEP 1 7 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 16-1924

I HEREBY CERTIFY, That I attended deceased from (Dec. 2) 1908, to Sept 16, 1924.

that I last saw him alive on Sept 16, 1924.

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration)..... yrs. 1 mos..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Charles P. Bell, M. D.

, 19 (Address) Wyliear - Rustenburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemy DATE OF BURIAL, Sept 17, 1924.

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 308 W. MONUMENT AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N Pine ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Parker

(a) RESIDENCE No 300 N Pine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 32 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary Parker
(Address) 317 Gorsuch St

15 SEP 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Heart disease

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D.
(Coroner.)
....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL National

DATE OF BURIAL Sept 17 1924

20 UNDERTAKER Leonard Whalen ADDRESS 623 Gorsuch St

NATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 90329

Registered No.

1-PLACE OF DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Asylum St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Shley

(a) Residence No. 230 North Vincent Street Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? unknown ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1890

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Painter

(b) General nature of industry, business, or establishment in which employed (or employer). 186

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Boris Shley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Hospital Records

(Address) Bay View Asylum Ward A

SEP 1 71924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/16/24

17- I HEREBY CERTIFY, That I attended deceased from 9-9, 19 24 to 9-16, 19 24, that I last saw him alive on 9-16, 19 24 and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

General metastasis.

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? (Colostomy)

Did an operation precede death? yes Date of May 15-1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) Ira P. Champion M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Hebron Rest	Sept 17, 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1824 E. Biddle

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 90330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90330

CERTIFICATE OF DEATH.

REGISTERED NO. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1225 Madison ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Holmes

(Residence in Baltimore: No. 1202 McCulloh St.: Montague Sanitorium yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE. Black | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, (Month) (Day) 1896 (Year)

7-AGE, 28 years. yrs. mos. da. | If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Palmyra N.C.

PARENTS.

10-NAME OF FATHER, James Holmes

11-BIRTHPLACE OF FATHER (State or Country), N. C

12-MAIDEN NAME OF MOTHER Cora Holmes

13-BIRTHPLACE OF MOTHER (State or Country), N. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Jones

(Address) Palmyra N C

15-

Filed ..... 192 ROBERT R. KRAUTER. Registrar.

SEP 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1924. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 4 1924. to Sept 15 1924. that I saw h[illegible] alive on Sept 15 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Post Operative, Hemorrhage,

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tonsillitis + Tonsillectomy.

(Duration) 1 yrs. 5 mos. ds.

(Signed) W. H. Montague M. D.

Sept. 15, 1924 (Address) 1225 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Accidental.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Carolina

PLACE OF BURIAL OR REMOVAL: Palmyra. N. C. | DATE OF BURIAL, Sept 18, 1924

UNDERTAKER: Sam W. Chase & Son | ADDRESS 1460 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90331

90 D 90331

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Traction ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Burk

(a) RESIDENCE NO. 1412 Traction ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) March 10-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Burk

(Address) 1412 Traction ave

15 Filed SEP 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924, to Sept 16, 1924, that I last saw h alive on Sept 16, 1924, and that death occurred, on the date stated above, at 12.50 Am.

The CAUSE OF DEATH* was as follows:

Angina pectoris

and Bright's

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred D Jewett, M. D.

(Address) 2574 Pennsa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 9/19/24

20 UNDERTAKER Geo. J. A. Gibson — ADDRESS 1735 Druid Hill

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90332

CERTIFICATE OF DEATH.

122-002

D 90332

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Gilmor ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Brown

(a) RESIDENCE NO. 1414 Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lucy Brown

6 DATE OF BIRTH (month, day, and year) July 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Lucy Brown (Address) 718 Gilmor St

15 Filed SEP 17 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924, to Sept 15, 1924, that I last saw him alive on Sept 15, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Fray M. D.

9/1, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemtery — DATE OF BURIAL Sept 18 1924

20 UNDERTAKER Mrs Jas H. Dennis per T. E. Kelson. — ADDRESS 1303 Pressman St

NOTE—PLEASE PRINT WITH INDELIBLE PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 90333

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 S. Clinton St., 16 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Gallaher

(a) Residence No. 1226 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Gallaher

6-DATE OF BIRTH (month, day and year) Feb. 17-1866

7-AGE. 58 yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm. Kemper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Pfort

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Frederick Kemper

(Address) 1226 S. Clinton St.

15- Filed Robert P. Harrison, Registrar.

Burial Permit Clerk.

P1 71924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 14-1924

17- I HEREBY CERTIFY, That I attended deceased from June 28 19 24 to Sept 13 19 24

that I last saw her alive on Sept 13 19 24

and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast, right
c Metastasis into
Mediastinum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C A Rupschneider M. D.

9/14 19 24 (Address) 2939 Easterwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oaklawn	Sept 18 1924
20-UNDERTAKER, Finkler & Finkler	ADDRESS 1739 Eager

Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH clearly. Terms should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH clearly. Terms should be carefully classified. Exact statement of OCCUPATION is very important. See. in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90334

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Elberts

(a) RESIDENCE NO. Brunswick Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) Sept 7, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Elberts

11 BIRTHPLACE OF FATHER (city or town) Union Bridge (State or country) Md

12 MAIDEN NAME OF MOTHER Alberta Sigafoose

13 BIRTHPLACE OF MOTHER (city or town) Brunswick (State or country)

14 Informant Clarence Elberts (Address)

P 1 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16- 1924

17

I HEREBY CERTIFY, That I attended deceased from 9-14, 1924, to 9-16, 1924, that I last saw him alive on 9-16, 1924, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) Life mos. ds.

CONTRIBUTORY (Secondary) maternal syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Signs, symptoms, autopsy

(Signed) Wm. Osler Rig, M. D.

(Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brunswick Md — DATE OF BURIAL: Sept 18 1924

20 UNDERTAKER: C. H. Zeltt & Son — ADDRESS: Brunswick Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90335

100 D 90335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Hebrew Stanley

(a) Residence No. 1302 Riggs St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1846

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town)... ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)... ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)...

15- Filed ..... 192.. Robert F. Harrison, Registrar.

Burial Permit Clerk.

P 1 7 1924

1781

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-15-24

17- I HEREBY CERTIFY, That I attended deceased from 3-2, 1924, to 9-15, 1924 that I last saw h— alive on 9-14, 1924 and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Heterocardia

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration)...yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of...

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Moore, M. D.

9-16 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER, ADDRESS

Commissioner of Health

SEP 17 1924

UNIVERSITY OF MARYLAND

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 90336

CERTIFICATE OF DEATH.

38 D 90336

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Grant McDaniel

(a) Residence No. 715 Carlyle St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1891

7-AGE,	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, Noah McDaniel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- 7/1924 192 Registrar.

ROBERT P. GRIFFITH,

Burial Permit Clerk.

1782

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-13-24

17- I HEREBY CERTIFY, That I attended deceased from 8-6 1924 to 9-13 1924

that I last saw him alive on 9-13 1924

and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis, Aneurysm of Arch of Aorta

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat. & X-ray

(Signed) Claude A. Drane M. D.

9-17 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
	192

20-UNDERTAKER. Commissioner Health. ADDRESS SEP 19 1924

Asst. Wm. E. WOODALL

UNIVERSITY OF MARYLAND

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P.1

INK—THIS IS A PERMANENT RECORD. Every item must be filled in. AGE should be stated EXACTLY. PHYSICIANS should write plainly, so that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 90337

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Mt Holly ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Walton Herbert

(a) RESIDENCE. No. 504 Mt Holly ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sngl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/13/08

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry F Herbert

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen McKeith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Harry F. Herbert.
(Address) 504 Mt Holly St

15 Robert T. Harrison, Registrar

SEP 17 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1924, to Sept 16, 1924, that I last saw him alive on Sept 16, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pericarditis and Endocarditis

Pneumonia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo L. Wisong, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Cemetery	9/19/24 19
20 UNDERTAKER Wilbur W. Shriver	ADDRESS 108 Edmondson Ave.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90338

CERTIFICATE OF DEATH.

D 90338

1-PLACE OF DEATH

Registered No. 114

City of BALTIMORE: (No. 1005 Russell St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..John Wehner

(a) Residence No. 1005 Russell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 18 1845

7-AGE, 78 yrs. 9 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George Wehner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara Stayton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Estelle Bayzle

(Address) 1005 Russell st

15- Filed ..... 19?

Robert P. Harrison, Registrar.

Burial Permit Clerk.

EP 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4th, 1924, to Sept. 15th 24, that I last saw h.[illegible] alive on Sept 15th, 1924, and that death occurred, on the date stated above, at 10 10 m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility + Arteriosclerosis

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Poulton, M. D.

Sept 16, 1924 (Address) 3909 Kanawha Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross Cemetery (Brooklyn) — DATE OF BURIAL, Sept. 18 1924

20-UNDERTAKER, James Dignan & Son — ADDRESS 1000 S. Paca St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ec—12-23-21—E.B.F.S.—400 Bks.

D 90339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90339

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 211 W. 23 Stuet St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street nnd number.)

2-FULL NAME. Saw Edward Wilgis

(a) Residence No. 211 W. 23rd Stuet St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5- yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wilgis

6-DATE OF BIRTH (month, day and year) Jan 21, 1860

7-AGE, 64 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work truck foreman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hanford Co., Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Jas. P. Wilgis

(Address) 211 W. 23 Stuet

15- FILED SEP 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1924 to Sept 16 1924

that I last saw him alive on Sept 15 1924

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of the Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H W Lane M. D.

9/18/24 (Address) 2106 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Fork M E Cemetery — DATE OF BURIAL, Sept. 18, 1924

20-UNDERTAKER, E. LeRoy Stifflen — ADDRESS 125 E North Ave.

Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Full instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90340

CERTIFICATE OF DEATH.

74-081 D 90340

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 223 E. North Ave. (ST.) 12 (WARD)

2-FULL NAME Lawrence D. Kehoe

(a) RESIDENCE. No. 223 E. North ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Ann Kehoe

6 DATE OF BIRTH (month, day, and year): [illegible] abt. 1841

7 AGE — Years: 83 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Thomas Kehoe.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mary Crane. (Address) 223 E. North Ave.

15 Filed . 19 Robert P. Harrison, Registrar

P 1 7 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12 . 1924 . to Sept 16 . 1924 . that I last saw h— alive on Sept 16 . 1924 . and that death occurred, on the date stated above, at 12 N m.

The CAUSE OF DEATH* was as follows:

1a Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Hr. Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry L. Wilson, M. D.

. 19 (Address) 3 W. Biddle St., Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Charles Petersville	Sept 18 1924
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld	501 E. 22d

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Tony 414 E N Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90341

D 90341

CERTIFICATE OF DEATH.

9 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2431 Guilford St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle McComas

(a) Residence No. 2431 Guilford St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 23 1866

7-AGE. 58 yrs. 8 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas H McComas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary E McDonald

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Thomas H McComas

(Address) 2431 Guilford

15- Filed SEP 17 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 30th 1924 to Sept 17th 1924

that I last saw h.. alive on Sept 17th 1924,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Acute Heart Disease

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Tonry, M. D

, 19 (Address) 414 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem. — DATE OF BURIAL, Sept 19, 1924

20-UNDERTAKER, Wm Cook & Co — ADDRESS Eutaw

Burial Permit Clerk

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90342

CERTIFICATE OF DEATH.

113 D 90342

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 719 S Rose ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Gurnsey

(a) RESIDENCE NO. 719 So Rose Stt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leonard Gurnsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Hoake

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Leonard Gurnsey

(Address) 719 South Rose.

15 Filed ....., 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 , 1924 , to Sept 14 , 1924 ,

that I last saw h.. alive on Sept 16 , 1924 ,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Cochran, M. D.

, 19 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Sept 18 1924
20 UNDERTAKER	ADDRESS
W. Cook	502 E Fayette Ave

P 17 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 1-08 D 90343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude E. Malone

(a) RESIDENCE NO. Liberty Heights & Roelke's Road

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy J. Malone

6 DATE OF BIRTH (month, day, and year) July 14th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Michael Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Margaret Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: T. J. Malone (Address) Liberty Heights near Rolling Road

15 Filed Robert P. Harrison, Registrar

P 1 71924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/24

17 I HEREBY CERTIFY, That I attended deceased from 9/4/24, 19..., to 9/14/24.

that I last saw her alive on 9/14/24

and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstit Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 18th 1924

20 UNDERTAKER: H. C. Brauning Son — ADDRESS 512 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90344

CERTIFICATE OF DEATH.

183

D 90344

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Theodore Heinekamp.

(a) RESIDENCE No. 9 Englewood Road. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. -- mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 27, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	0	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Rudolph J. Heinekamp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER May V. Cooke.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Rudolph J. Heinekamp. (father)
(Address) 9 Englewood Road.

15 SEP 18 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound in back. Spinal column cut in two, Rectum perforated. Shot by a boy while at play. Accidental Death. (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis. (duration) yrs. mos. 3 ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Feb. 17, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Pikesville Balto. Co. Md. Feb. 13. 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Sept 19 1924

20 UNDERTAKER Henry W. Jenkins & Co ADDRESS Eutaw & McCulloh St

MAKE ENTRIES WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Joshua Downs.

D 90345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 90345

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 - W - Lexington ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Downs

(a) RESIDENCE No. 1618 - W - Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Jobbing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Rivr Md

PARENTS

10 NAME OF FATHER William Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country) a. a. Co Md

12 MAIDEN NAME OF MOTHER Alice Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) a. a. Co Md

14 Informant Susie Downs (Address) 1518 W Lexington st

15 SEP 18 1924 ROBERT R. GRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Sept 15, 1924, that I last saw h alive on Sept 15, 1924, and that death occurred, on the date stated above, at 7. 30 P m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J. Fontrose, M. D.

, 19 (Address) 1618 W - Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Sept 18th 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor St

A.K.S. • S. E. A.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90346

D 90346

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1738 E. Chase St. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary J. Wise

(a) Residence No. 1738 E. Chase St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Wise.

6-DATE OF BIRTH (month, day and year) Oct. 1853.

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14-(Informant) Catherine Wise.

(Address) 304 S. 3rd St.

15-FILED SEP 18 1924 ROBERT S. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 16-1924

17-I HEREBY CERTIFY, That I attended deceased from Aug. 1. 1923 to Sept 16 1924

that I last saw h[illegible] alive on Sept 16 1924

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cortex & Mutat Regurgitation

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. C. Rosenback M. D.

Sept 17 1924 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF INTERMENT, CREMATION OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Sept. 18, 1924

20-UNDERTAKER, Lilly & Zile ADDRESS 403 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90347

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Frank

(a) Residence No. 625 N. Port St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 22-1893

7-AGE. 30 yrs. 9 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Box factory

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Conrad Frank

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, Kunigunda Loeffler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ger.

14- (Informant) Conrad Frank

(Address) 625 N. Port St

15- Filed SEP 18 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 3, 1924 to Sept 16 1924

that I last saw her alive on Sept 16, 1924

and that death occurred, on the date stated above, at 1 30 p.m.

The CAUSE OF DEATH* was as follows:

T. B. Peritonitis

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 4/24

Was there an autopsy? no

What test confirmed diagnosis? Surg. & Clin.

(Signed) Geo. L. Seybert M. D.

, 19 (Address) St. Josephs Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Sept. 19, 1924

20-UNDERTAKER. Lilly and Zeiler — ADDRESS 403 S. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 90348

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 636 S. Curley St St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph G. Hartman

(a) Residence No. 636 S. Curley St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Hartman

6-DATE OF BIRTH (month, day and year) Oct 17-1854

7-AGE.	If LESS than 1 day.
69 yrs. 11 mos. 0 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stone cut

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER. John Hartman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany.

14- (Informant) Mary H. Hartman

(Address) 636 S. Curley St.

15- Filed SEP 18 1924, 19.., ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 17-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10 ....., 1921 ..., to Sep 16 ....., 1924.

that I last saw h. alive on Sep 16 ....., 19 24

and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

3

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

....., 19 (Address) 301 S Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart Cem.	Sept. 20, 1924
20-UNDERTAKER. Lilly and Zeile	ADDRESS 403 S Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90349

CERTIFICATE OF DEATH.

74-001

74 D 90349

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4000 Falls Road (St.,) 13 (Ward)

2-FULL NAME Charles A. McSherry

(a) RESIDENCE No. 4000 Falls Road. (St.,) 13 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle McSherry

6 DATE OF BIRTH (month, day, and year) June 24- 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) Wm. E. Hooper & Sons

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles A. McSherry

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary V. Adams

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs Myrtle McSherry

(Address) 4000 Falls Road

SEP 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. ....., 1924, to Sept. 16, 1924.

that I last saw h in alive on September 16, 1924.

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

..... (duration) yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral appoplexy

..... (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? two Date of .....

Was there an autopsy? two

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Hankin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Sept 19 1924

20 UNDERTAKER Howard A. Burgee — ADDRESS 363 Falls Rd

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90350

CERTIFICATE OF DEATH.

100-001

REGISTERED No. D 90350

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raynor ave + Dukeland st ST., 17 WARD)

2-FULL NAME Mrs Myrtle Bayne

(a) RESIDENCE NO. 2710 Huntington ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wife of Clarence Bayne

6 DATE OF BIRTH (month, day, and year) July 29 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Edwin Royston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Virginia Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Mr. Edwin Royston (Address) 2710 Huntington Ave

15 Filed SEP 18 1924 ROBERT A. KRAUTER, Registrar

16 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept. 16, 1924, that I last saw her alive on Sept. 16, 1924, and that death occurred, on the date stated above, at 12:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic, Parenchymatous Interstitial Nephritis

— (duration) — yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

1 — 2 — leaves (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept. 15. 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Operative

(Signed) Clement R. Monroe, M. D.

, 19 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence Cemetery Balto Co — DATE OF BURIAL Sept 19 1924

20 UNDERTAKER A S Marshall 3539 Fall Rd — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 90351

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1436 Homestead St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Dey

(a) Residence No. 1436 Homestead St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Dey

6-DATE OF BIRTH (month, day and year) June 5th, 1847

7-AGE, 77 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House -work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York State

PARENTS.

10-NAME OF FATHER, William Simon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York State

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

Informant) Son (Informant) Judson Dey

(Address) 1436 Homestead St.

Filed SEP 18 1924 ROBERT N. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 16 1924

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1924 to Sept 16 1924

that I last saw h[illegible] alive on Sept 16 1924

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Sept 18, 1924 (Address) 1107 Eutaw Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL, Sept. 19, 1924

20-UNDERTAKER Elmer M. Conkling

ADDRESS 924 E. Eager St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002
D 90352

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green STS. 16 WARD)

2-FULL NAME Charles Wyatt

(a) RESIDENCE NO. 741 West Lombard St., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Murphy Wyatt.

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Court House

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Robt C Wyatt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Louisa A Gaiphar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Orleans

14 Informant Mrs Annie M Wyatt
(Address) 741 W Lombard St

15 Filed SEP 18 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 24, to Sept 16, 19 24, that I last saw h. alive on Sept 16, 19 24, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Sept 8 (Duration) yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) Probably due to

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of Sept 7-1924

Was there an autopsy? No

What test confirmed diagnosis? Cardinal Symptoms

(Signed) W Wallace Walker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 20 1924

20 UNDERTAKER John F Cowan & Son

ADDRESS Gorsuch Ave

Peter J F Cowan

Burial Permit Issued

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90353

100-001

D 90353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 29 S Schroeder St St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Thelma F Fahnigen

(a) Residence No.... 29 S Schroeder St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 18-1923.

7-AGE.	If LESS than 1 day.
....yrs....mos. 30 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William F. Fahnigen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Florence W Brady

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mr William F Fahnigen

(Address) 29 S Schroeder St

SEP 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 15, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924 to Sept 15, 1924.

that I last saw h.....alive on....., 19.....,

and that death occurred, on the date stated above, at 1. A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Ovaries

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis V. Carahan M. D.

, 19 (Address) 24 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Sept 18, 1924
20-UNDERTAKER.	**ADDRESS.**
John J. Cowan & Son	90 Holbrook St

IMPORTANT. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90354

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Bruce ST., 16 WARD)

2-FULL NAME John Harrow Brown

(a) RESIDENCE NO 711 N Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Thos.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice Barrett 711 N. Bruce St.
(Address)

15 (ROBERT N. KRAUTER,) Registrar

SEP 18 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsies or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

(Signed) C. E. Blades, M. D.
(Coroner.)

Sept 17 24 (Address) 1423 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Sept 18 24

20 UNDERTAKER: Edward Kemp & Bro | ADDRESS: Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90355

CERTIFICATE OF DEATH.

D 90355

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2524 Custer Place St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Irene Tinkler

(a) Residence No. 2524 Custer Place St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE) Samuel Tinkler

6-DATE OF BIRTH (month, day and year) June 13. 1889

7-AGE. 35 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Oliver L Owens

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Cassandra Hancock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Samuel Tinkler

(Address) 2524 Custer Place

SEP 18 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Sept 16 1924, that I last saw h.. alive on Sept 16 1924, and that death occurred, on the date stated above, at 8 A m. The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ..... yrs. 5 mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J Wells, M. D

, 19 (Address) 2 E Belvedere Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 19, 1924
20-UNDERTAKER.	**ADDRESS**
Martin Fakes & Son	1827 W North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 D 90356

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Rayner ave + Auckland at ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Henry Jewell Jr.

(a) RESIDENCE No. 2721 St Paul - ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Spruit Jewell

6 DATE OF BIRTH (month, day, and year) Feb. 15 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	7	2	

8 OCCUPATION OF DECEASED U.S. Vocational

(a) Trade, profession or particular kind of work Training - (Bawdry Racing)

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Mr Henry Jewell -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel co - Md

12 MAIDEN NAME OF MOTHER Miss Eulah Prather

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel co Md -

14 Informant Wife Louisa S Jewell (Address) 3644 W. Norell Ave

15 Filed SEP 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 12 , 1924 , to Sept 17 , 1924 , that I last saw him alive on Sept 17 , 1924 , and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis (appendix Ruptured)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus - Cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Sept 12 .

Was there an autopsy? no

What test confirmed diagnosis? Operation .

(Signed) Clement R. Monroe . M. D.

, 19 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Sept 19, 1924
20 UNDERTAKER	ADDRESS
W J Pickner Sons	Norell Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90357

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1805 N. Callington St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Clemson

(a) Residence No. 1805 N. Callington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-(Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or ~~WIFE of~~) Lemuel H. Clemson

6-DATE OF BIRTH (month, day and year) 1866 - June 2nd

7-AGE. 58 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania Hanover Co Md

PARENTS.

10-NAME OF FATHER, Augustus Koontz

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Hanover Co Md

12-MAIDEN NAME OF MOTHER, Laura V. Charles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cumberland Md

14-(Informant) Lemuel Clemson

(Address) 1805 N. Callington Av

15- Robert P. Harris, 192 Registrar.

P 1 81924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22nd 1924 to Sept. 18th 1924

that I last saw he alive on Sept 17th 1924

and that death occurred, on the date stated above, at 7.30 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis 5 yrs
(Duration)
CONTRIBUTORY (Secondary) acute Dilatation
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Palpation & Percussion

(Signed) Emma Jones M. D.

Sept 18th 1924 (Address) 2802 Rayner Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Sept 22, 1924

20-UNDERTAKER, Edw. Leech & Son — ADDRESS 501 E. Hunt Av

ENDORSED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90358

CERTIFICATE OF DEATH.

5V D 90358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 W. Fort ave. ST., 23 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Vogelsang

(a) RESIDENCE NO. 129 W. Fort ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14. 1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Louis Vogelsang

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Hill

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Mrs. Mary Vogelsang
(Address) 3023 Edmondson ave.

15 Sept 18 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1924, to Sept 16, 1924, that I last saw h[illegible] alive on Sept 16, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) — yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Wheatley M. D.

9/17 1924 (Address) 1299 Williams

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 19 1924
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St.

MARK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apt ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura G. Whitehill

(a) RESIDENCE NO. Riviera Apt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Entire mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or:) WIFE of Henry M Whitehill

6 DATE OF BIRTH (month, day, and year) Oct. 4th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Levi Grief.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hennie Eberlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Milford Whitehill Riviera Apt

15 Filed ....., 19.... Registrar

Robert P. Harrison, Burial Permit Clerk.

SEP 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17th 1924

17

I HEREBY CERTIFY, That I attended deceased from June, 1919, to Sept. 17, 1924

that I last saw her alive on Sept. 17, 1924

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Lab. Tests.

(Signed) Joseph William Kelly, M. D.

19 (Address) 910 Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew — DATE OF BURIAL: Sept 19th 1924

20 UNDERTAKER: Ward Goodheim — ADDRESS: 1184 N Howard

IMPORTANT—THIS IS A PERMANENT RECORD. Every item must be written with INDELIBLE INK—WRITE PLAINLY. Every question must be answered. AGE should be carefully supplied. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90360

D 90360

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 421 S. Belair Road St., Rosedale Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. Miller

(a) Residence No. 421 S. Belair Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George E. Miller

6-DATE OF BIRTH (month, day and year) Sept. 23 1859

7-AGE. 64 yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) Carroll Co.
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER Preston Jeffs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Elisa Farrell

13-BIRTHPLACE OF MOTHER (city or town) Frdk Co. (State or Country), Maryland

14- (Informant) George E. Miller

(Address) 421 S. Belair Rd. Rosedale

15-

Filed SEP 18 1924 Robert P. Harrison, Registrar.

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 17th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 24 to Sept 17, 19 24

that I last saw h alive on Sept 17, 19 24,

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation with

Muscular Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation (Heart)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Smith, M. D.

9/17, 19 24 (Address) 4 W Hamilton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Granted

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Paul's M. E. Cemetery

DATE OF BURIAL, Sept. 19, 1924

20-UNDERTAKER Fred'k Lassahn & Sons

ADDRESS Fullerton

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90361

CERTIFICATE OF DEATH.

1924 D 90361

1-PLACE OF DEATH Pronounced Dead at

CITY OF BALTIMORE: (No. St Joseph Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Dombrowski

(a) RESIDENCE NO. 2726 O'Donnell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) April 2, 192[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Daniel Dombrowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislawa Pryzybylska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant Daniel Dombrowski
(Address) 2726 O'Donnell St

15 Filed SEP 18 1924 ROBERT R. KRAUTER, Registrar
Burial Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 192[illegible]

17 I HEREBY CERTIFY, That I took charge of remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
while playing near Harbor

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Henderson M. D.
(Coroner.)

Sept 17, 192[illegible] (Address) 700 Chauncey

*(State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Polish National Cem. DATE OF BU[illegible]

20 UNDERTAKER M. J. Sadowski ADDRES[illegible] 705 [illegible]

Spec.—1-10-21—M&T—1500 Blks.

D 90362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90362

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence J. Ridgely

(a) RESIDENCE No. 734 Reservoir ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. S. W. K. Ridgely

6 DATE OF BIRTH (month, day, and year) Mar. 30, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm. Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Scarborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Florence J. Ridgely (Address) 734 Reservoir

15 SEP 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1924, to Sept 18, 1924, that I last saw her alive on Sept 18, 1924, and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Gastritis. Cardiac decompensation (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [illegible], M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 20 1924

20 UNDERTAKER Chas. G. Black — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90363

CERTIFICATE OF DEATH.

161-9 90363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N. Fremont Ave St. 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Robert Manners, Jr.

(a) RESIDENCE NO. 603 N. Fremont Ave St., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18-1924

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. 40 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Robert Manners.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Augusta Graef

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Edward Robert Manners. (Address) 603 N. Fremont Ave.

15 Filed SEP 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 18, 1924, that I last saw him alive on Sept 18, 1924, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland, M. D.

9-18-1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL Sept 19 1924

20 UNDERTAKER Mrs. Mrs. John H. Teufel & Son — ADDRESS 801 W. Fayette

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90364

D 90364

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hosp. ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Walter M Kelley

(a) RESIDENCE NO. 845 Hollins ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Kelley

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Walter M. Kelley, (Address) 845 Hollins St ~~KRAUTER~~

15 Filed SEP 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1924, to Sept 15, 1924, that I last saw him alive on Sept. 18, 1924, and that death occurred, on the date stated above, at 6:15 p. m.

The CAUSE OF DEATH* was as follows:

General carcinomatosis

(duration) 7 yrs.) mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) 15 minutes yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4-4-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Wm A Thompson M. D.

9-18 1924 (Address) Md Gen'l Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Union Park Cem	Sept 20 24
20 UNDERTAKER Wm E L B Cook	ADDRESS 1003 W Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90365

CERTIFICATE OF DEATH.

179 D 90365

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Shepperd

(a) RESIDENCE No. 535 Vincent St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asbury Shepperd.

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 [illegible] William Howard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Asbury Shepperd
(Address) 1108 Vincent St

15 SEP 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns body, arms & face

(duration) 9 hours & 5 minutes

CONTRIBUTORY (Secondary) Set window Curtain afire lightning her pipe ds.

(Signed) Thos. B. Norton M. D. (Coroner.)

Sept 18, 1924 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Fire.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 9/19/24 1924

20 UNDERTAKER Daniel Easton ADDRESS Essex

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Roll.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90366

CERTIFICATE OF DEATH.

44

REGISTERED NO. D 90366

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 928 Carr ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Foyler Noll

(a) RESIDENCE NO. 928 Carr ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dale

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer University Club

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Davis. (Address) 640 Saratoga St.

15 SEP 16 1924 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30th, 1924 to Sept 17 1924

that I last saw h[illegible] alive on Sept 17 1924

and that death occurred, on the date stated above at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Fen Ellis, M. D.

, 19 (Address) 72 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W M Auchmuty Lot — DATE OF BURIAL 9/19/24

20 UNDERTAKER Daniel Easton — ADDRESS 916 Eutaw

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90367

CERTIFICATE OF DEATH.

1888 D 90367

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N Carey ST., 15 WARD)

2-FULL NAME Griffin Lee

(a) RESIDENCE NO. 1315 N Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Lee

6 DATE OF BIRTH (month, day, and year) May 6 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Expressman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Griffin Lee Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Workman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Josephine Lee
(Address) 1315 N. Carey

15 Filed SEP 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident

Contused Chest & Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) Jno Clinton Blades, M. D.
(Coroner)

Sept 19/24 192 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 22 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90368

CERTIFICATE OF DEATH.

D 90368

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 Calvaudar St., 21 Ward)

Registered No.....

2-FULL NAME Mary Ellen Schisler

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 508 Calvaudar St., ... Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 20th 1923

7-AGE. ..... yrs. 10 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS

10-NAME OF FATHER. Stanley J Schisler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER. Marion D. Rouse

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Boston Mass

14- (Informant)... Stanley J. Schisler

(Address)..... 508 Calvaudar St.

15- SEP 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/17/24

17- I HEREBY CERTIFY, That I attended deceased from 9/17/24, 19..... to 9/17/24, 19 24

that I last saw h.. alive on 9/17/24, 19 24

and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Cystic Endocarditis

(Duration) ..... yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Millard Dixon M. D

, 19 (Address) 1709 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL, Sept 19 19 24

20-UNDERTAKER, E Schulman & Son — ADDRESS 1039 Hanover St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90369

CERTIFICATE OF DEATH.

129 D 90369

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1122 N. Mount ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jones

(a) RESIDENCE NO. 1402 Brunes dl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 - 1814

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 049

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maurice Jones

(Address) 1402 Brunes st.

15 SEP 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept , 19 24 to Sept 18 , 19 24 ,

that I last saw him alive on Sept 18, , 19 24 ,

and that death occurred, on the date stated above, at 4:27 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Edward L Novak M. D.

, 19 (Address) 716 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 21/1924
20 UNDERTAKER Virginia A. Brooks	ADDRESS 1463 N Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90370

CERTIFICATE OF DEATH.

113 D 90370

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Stockton ST., 16 WARD)

2-FULL NAME Clemit Marks

(a) RESIDENCE NO. 1118 Stockton ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Richard Marks

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mrs Ella Conway

13 BIRTHPLACE OF MOTHER (city or town) Lancaster
(State or country) Va.

14 Informant Ella Conway
(Address) 1118 Stockton St

15 SEP 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 16 , 1924 , to Sept 19 , 1924 ,
that I last saw him alive on Sept 17 , 1924 ,
and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Harry E. Saunders, M. D.

, 19 (Address) 1133 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 18 1924

20 UNDERTAKER Virginia A. Brooks — ADDRESS 1463 N Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Collier

(a) RESIDENCE No. Foster ave Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Collier

6 DATE OF BIRTH (month, day, and year) Mar 14 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Salt Copper Works Balto City

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Geo. W. Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. W. Collier (Address) 1410 N Bond St

15 Filed ....., 192.. KUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed Skull & Internal Body Injuries Accidental - Electrocution

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Instant

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFaulon, M. D. (Coroner.)

Sept 17, 1924 (Address) 733 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Clinton & O'Donnell Sts

Former or usual residence Patty Hill Balto

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 9/19 1924

20 UNDERTAKER H. W. Meaux & Son — ADDRESS Balto Md

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90372

CERTIFICATE OF DEATH.

D 90372
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Cereal ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Cwalina

(a) RESIDENCE No. 5 Cereal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard. Cwalina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances. Skarlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Bernard. Cwalina
(Address) 5 Cereal Street

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

SEP 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1924, to Sept. 18, 1924,
that I last saw her alive on Sept. 18, 1924,
and that death occurred, on the date stated above, at 4. P. m.
The CAUSE OF DEATH* was as follows:

Diphtheria (nasal & laryngeal)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? on a farm.
Did an operation precede death? no Date of no
Was there an autopsy? no
What test confirmed diagnosis? Physical examination
(Signed) N. Alpert, M. D.
, 19 (Address) 2350 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.Co. Sep	19 1924
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK IS A PERMANENT RECORD. DATA GIVEN HEREIN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90373

CERTIFICATE OF DEATH.

3 | D 90373

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 433 Hutchins Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Simeon

(Residence in Baltimore: No. 433 Hutchins Ave, Govans St.; 27 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~ (*Write* the word.) Yes

6-DATE OF BIRTH, April (Month) 31 (Day), 1881 (Year)

7-AGE, 43 - 5 - 15 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Eubanks

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Hannah Dove

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Eubanks (Mother)

(Address) 433 Hutchins Ave

15-

Filed....., 191.....

SEP 19 1924 ROBERT R. KRAUPE, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1924 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 3 1923, to Sept. 16 1924, that I saw her alive on Sept 15 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH was as follows:

*Pneumonia

(Duration) 1 yrs. 5 mos. 15 ds.

CONTRIBUTORY (Secondary) General Debility and Old Age

(Duration) 1 yrs. 5 mos. 15 ds.

(Signed) [illegible] M. D.

Sept 17, 1924 (Address) 1225 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Sept 19, 1924

20-UNDERTAKER Samuel J. Kinsley

ADDRESS W. Balto

CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90374

CERTIFICATE OF DEATH.

74-001

D 90374

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1712 McCulloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bolden

(a) Residence No. 1712 McCulloh St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of Thos Bolden

6-DATE OF BIRTH (month, day and year) Dec 10/80

7-AGE. 43 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Ky.
(State or Country),

PARENTS.

10-NAME OF FATHER. Harry Slaughter

11-BIRTHPLACE OF FATHER (city or town) Bowling Green
(State or Country), Ky.

12-MAIDEN NAME OF MOTHER. Harriet Slaughter

13-BIRTHPLACE OF MOTHER (city or town) Bowling Green
(State or Country), Ky.

14- (Informant) Thos Bolden

(Address) 1712 McCulloh

15- SEP 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 17/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Sept 17 1924

that I last saw h[illegible] alive on Sept 15 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

10 minutes (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

6 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? 0

9/18. 1924 (Signed) H. S. McCard M D

(Address) 2005 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
[illegible]	Sept 20 1924
20-UNDERTAKER. Samuel H. Kinsley & Bro	ADDRESS 578

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 860 Penn ave ST., 18 WARD)

REGISTERED NO. 1478

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margt Tilghman

(a) RESIDENCE NO 860 Penn ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Lewis Wms

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Belle Wms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Chas A Tilghman
(Address) 860 Penn ave

15 Received SEP 19 1924 ROBERT N. KRAUTH, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

....(duration) ....yrs. ....mos. ....ds.

(Signed) ....(Coroner.), M. D.

....., 192 ....(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 19 1924
20 UNDERTAKER Samuel Hursley	ADDRESS W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90376 — 99-002 — D 90376

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 200 Poplar Ave Ward 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli A. Beatty

(a) Residence No. 200 Poplar Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Beatty

6-DATE OF BIRTH (month, day and year) Dec 22, 1851

7-AGE. 72 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Moulder

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Isaac Sheppard

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: William Beatty

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Julia - Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Anna Beatty

(Address) 200 Poplar Ave, Overlea

15- SEP 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 24 to Sept 17, 19 24

that I last saw h. m. alive on Sept 16 19 24

and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 1- yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) C. Theo Hubard M. D.

9/17, 1924 (Address) 1 Cathedral Bk Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	Sept 20, 1924
20-UNDERTAKER. H. Sauder Sons	ADDRESS 1710 Pleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90377

CERTIFICATE OF DEATH.

127-001
127 90377

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 923 Binney St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Stockman

(a) Residence No. 923 Binney St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Stockman

6-DATE OF BIRTH (month, day and year): June 17 1857

7-AGE: 67 yrs. 3 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none At home
(b) General nature of industry, business, or establishment in which employed (or employer): house work & [illegible]
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John P. Bollack

11-BIRTHPLACE OF FATHER (city or town) (State or Country): not known Germany

12-MAIDEN NAME OF MOTHER: Catherine Miles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): not known Germany

14- (Informant) William J. Stockman
(Address) 1107 E. Potomac St.

15-
Filed ..... 192.....
SEP 19 1924 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 17/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1924 to Sept 17 1924

that I last saw h[illegible] alive on Sept 17 1924

and that death occurred, on the date stated above, at 11 40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) for several years

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Sept 19. 1924 (Address) 1014 S. Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem.	Sept 21. 1924
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Pleasant St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D 90378

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged & Infirm ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fozie Klatzovskiy

(a) RESIDENCE. NO. 2100 E Baltimore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chaim Klatzovskiy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1429 E Baltimore St

15 Filed SEP 19 1924 ROBERT R. KRAUTER, Registrar

Municipal Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1924, to Sept 18, 1924, that I last saw h W alive on Sept 17, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

ch. nephritis.
Senility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Levinthal, M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	9/19 1924

20 UNDERTAKER Jack Lewis 1429 E Baltimore St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D 90379

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (BACHMANN) ST., 4 WARD)

2-FULL NAME Mr. George F. Bachmann

(a) RESIDENCE NO. Annapolis Boulevard Landsdowne Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? 36 yrs. 5 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Catherine Bachmann

6 DATE OF BIRTH (month, day, and year) Oct 1 1849

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mason

(b) General nature of industry, business, or establishment in which employed (or employer) Laying Stone 886

(c) Name of employer No permanent

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs Catherine Weigand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Bachman, Landsdowne Md. (Address)

Filed SEP 19 1924 ROBERT A. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Sept 18, 1924, that I last saw him alive on Sept 18, 1924, and that death occurred, on the date stated above, at 5 15 AM m.

The CAUSE OF DEATH* was as follows:

Parenchymal Tuberculosis, Pulmonary

Exhaustion and Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of Sept 17, 1924

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Jas. J. Mard, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bachman Cemetery	Sept 20 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90380

HEALTH DEPARTMENT—CITY OF BALTIMORE

104-002

90380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Broadway, Fairmount ST., ... WARD)

2-FULL NAME Miss Doris K. Robb.

(a) RESIDENCE NO. 203 N. Bradford St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 18/19

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Joseph Robb

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Joseph Robb
(Address) 203 N Bradford St

15 SEP 19 1924 ROBERT N. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 17 , 1924 , to Sept. 18 , 1924 , that I last saw h[illegible] alive on Sept. 18 , 1924 and that death occurred, on the date stated above, at 1.26 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis —
(cause unknown) Autopsy

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept. 17, 1924

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. E. Rice , M. D.

, 19 (Address) Church Home + Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 20 1924
20 UNDERTAKER Frank Enoch Son	ADDRESS 1906 Eutaw

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90381

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Gough ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Miller

(a) RESIDENCE NO. 2115 Gough ST., 1 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholas Miller

6 DATE OF BIRTH (month, day, and year): Jan 2 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
4/8		8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balt. City

PARENTS

10 NAME OF FATHER: Samuel Winks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Maria Cleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt City

14 Informant: Nicholas Miller

(Address): 2115 Gough St.

15 Filed SEPT 9 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-17 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 - , 1927, to Sept 17, 1924, that I last saw h[illegible] alive on Sept 17, 1924 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Decompensation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Manuel Dunkes, M. D.

, 1924 (Address) 325 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. A.A. Co

DATE OF BURIAL: Sept 20 1924

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 4038 Woodland

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS PARAGRAPH, WITH CAUTIONARY NOTICE, SHOULD BE READ CAREFULLY BEFORE ANY ITEM OF INFORMATION IS FILLED IN. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90382

CERTIFICATE OF DEATH.

100-001 D 90382

174640

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Lee

(a) RESIDENCE NO. 1234 Pennsylvania ST. Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 SEP 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1924, to Sept 14, 1924, that I last saw him alive on Sept 14, 1924, and that death occurred, on the date stated above, at 10.15 P.m.

The CAUSE OF DEATH* was as follows:

1. Jaundice - unexplained
2. Bronchopneumonia
3. Otitis media

(duration) 1. 2 weeks 2. 9 days 3. 2 months

CONTRIBUTORY — (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Bur Health, Pass Wm. E. Woodall

ADDRESS SEP 19 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90383 CERTIFICATE OF DEATH. 438 D 90383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Vasque

(a) RESIDENCE NO. Clarksburg, W. Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Manual Vasques

6 DATE OF BIRTH (month, day, and year) March 22, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Leon Dalton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Chadwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant

(Address)

15 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

SEP 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1924, to Sept 13, 1924, that I last saw her alive on Sept 13, 1924, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Neurosyphilis

(duration) + yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Work

(Signed) Anton G. Rytina, M. D.

, 19 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Jos. Weber Heath.

ADDRESS

Asst. Wm. H. WOODALL

SEP 19 1924

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 90384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 90384

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Taylor Ave ST., 9 WARD)

2-FULL NAME Infant Miller

(a) RESIDENCE NO. 2121 Taylor Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of nine

6 DATE OF BIRTH (month, day, and year) Sept 18/24

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6hrs	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Leo Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Katrina Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Leo. Miller (father)
(Address) 2121 Taylor Ave

15 Filed SEP 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity
(7 to 8 monsl Gestation)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. McCarn, M. D.
(Coroner.)

9/18/24, 192 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 20, 1924
20 UNDERTAKER Richard F. Cuskey	ADDRESS 1089 Guilford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90385

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Athol Ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Cook Brown

(a) RESIDENCE NO. 5 Athol Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs H C Brown

6 DATE OF BIRTH (month, day, and year): Aug 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: C Howard Brown

(Address): 5 Athol Ave

SEP 19 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1921 to Sept 17 1924.

that I last saw him alive on Sept 17 1924

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall B Wroth, M. D.

Sept 19 1924 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	9/20 1924
20 UNDERTAKER: George A Farley	ADDRESS: Fulton Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK. EVERY item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

oc—12-23-21—E.B.R.S.—400 Bks.

Lucy Henkel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90386

CERTIFICATE OF DEATH.

D 90386

1-PLACE OF DEATH

City of BALTIMORE: (No. 4700 Edna Ave Ward 27) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Henkel

(a) Residence No. 4700 Edna Ave St. Lauraville Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Sing

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 5 1836

7-AGE, 87 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henkel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Lena Henkel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Theodore Smith

(Address) 4700 Edna Ave Lauraville

15-

FILED SEP 19 1924

Robert P. Harrison,
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 19 24

17- I HEREBY CERTIFY, That I attended deceased from about June 15, 19 24 to Sept 19, 19 24,

that I last saw h.. alive on....., 19.....,

and that death occurred, on the date stated above, at 12.05 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

Mitral Insufficiency (Duration).....yrs.....mos.....ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

9/17, 19 24 (Signed) Chas Jones, M. D.

(Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Louis Cem. — DATE OF BURIAL, Sept 22, 1924

20-UNDERTAKER, Long Green. — ADDRESS 801 W. Fayette

M & Mrs. John W. Deufel & Son

SEP 19 1924

IMPORTANT—Answers must be written legibly. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90387.

CERTIFICATE OF DEATH.

16-002 D 90387

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 W. Lanvale ST.: 16 WARD)

2-FULL NAME Robert Wm Morrow

(a) RESIDENCE. NO. 2914 W. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 30 1924.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edwin J Morrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltomd.

12 MAIDEN NAME OF MOTHER Evelyn Meeks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltomd.

14 Informant (Address) Ed. J Morrow 2914 W. Lanvale St

15 Filed SEP 19 1924 19 Robert P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Sept 18, 1924, that I last saw h. alive on Sept 18, 1924 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis - Bacillary type - Bacillus undetermined.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

Sept 19 1924 (Address) 2901 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 20, 1924

20 UNDERTAKER Wm. Leo Koch - Vice Pres. ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—J-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90388

CERTIFICATE OF DEATH.

90388

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3546 Cedar Ave ST., 13 WARD)

2-FULL NAME Anna Wilhelmina Diven

(a) RESIDENCE NO. 3546 Cedar Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elmer H Diven

6 DATE OF BIRTH (month, day, and year) Feb 23 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Carl C Carlson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark Germany

12 MAIDEN NAME OF MOTHER Emma J Petersen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark Germany

14 Informant Elmer H Diven
(Address) 3546 Cedar Ave

15 ..... 19 ..... Registrar

P 1 97924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to Sept. 18, 1924, that I last saw h.. alive on Sept 16, 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

..... (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

..... (duration) ..... yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. W. Downey, M. D.

..... 19 (Address) 1612 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sept 22 1924
20 UNDERTAKER	ADDRESS
H S Marshall	2539 Falls Rd

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-2—E.B.&S.—400 Bks.

Hawkins

D 90389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90389

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1525 Light St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Decker

(a) Residence No. 1525 Light St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian E. Decker

6-DATE OF BIRTH (month, day and year) Apr. 3 1873

7-AGE.	If LESS than 1 day,
51 yrs. 5 mos. 16 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS

10-NAME OF FATHER. Christian Decker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Mrs. John C. Decker

(Address) 1525 Light St.

15- SEP 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1924 to Sept 19, 1924.

that I last saw him alive on Sept. 17, 1924

and that death occurred, on the date stated above, at 12.30A.

The CAUSE OF DEATH* was as follows:

Angina pectoris.

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arterior sclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D

9/19 1924 (Address) 1 E. Randall St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	9. 22. 24 19
20-UNDERTAKER, I. Few McCauley	ADDRESS 130 E. Fot

SHOULD BE CAREFULLY EXECUTED. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 90390

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Schaffer Ave. (ST.) Hamilton (WARD)

2-FULL NAME Christine M. Heinz

(a) RESIDENCE NO. 3 Schaffer Ave (ST.) Hamilton WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Philip P. Heinz

6 DATE OF BIRTH (month, day, and year) April 11th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Herrmann

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Harp

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Charles Heinz
(Address) 3 Schaffer Ave. Hamilton

15 Filed ..... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 1924, to Sept 18, 1924.

that I last saw h alive on Sept 17 1924

and that death occurred, on the date stated above, at 9:40 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of scalp

Brain (duration) metastatic yrs. mos ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Jones M. D.

9/18 1924 (Address) 4726 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 22 1924
20 UNDERTAKER	ADDRESS
Fredk Lauer & Sons	Fulleston

P 2 1924

THIS PAPER MUST BE CAREFULLY PRESERVED. Only ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90391

CERTIFICATE OF DEATH.

D 90391

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 N. Monroe ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Baby) Burns.

(a) RESIDENCE NO. 831 N Monroe ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18. 24

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fred Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Lillie Osborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Fred. Burns
(Address) 831 N Monroe

15 SEP 20 1924 19.. Robert P. Hartzell, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1924, to Sept 19, 1924, that I last saw her alive on Sept 19, 1924, and that death occurred, on the date stated above, at 6-30 p m.

The CAUSE OF DEATH* was as follows:

Acute Otitis

..... (duration) ..... yrs. ..... mos 1 hr

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. Lyman Rogers, M. D.

(Address) Sept 20 1924 831 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland — DATE OF BURIAL: Sept 20 1924

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS 1739 Eager

WHERE PLURAL NAMES, INITIALS OR ABBREVIATIONS ARE USED, EACH INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Settle 2435 Maryland Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90392

CERTIFICATE OF DEATH.

83 D 90392

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 524 N Stricker ST., 19 WARD)

2-FULL NAME Mary Frances Henderson

(a) RESIDENCE NO. 524 N Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND (or) WIFE of: Archie L Henderson

6 DATE OF BIRTH (month, day, and year): Nov 13, 1853

7 AGE: Years 70 Months 10 Days 6 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: Samuel Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Eliza Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: H Edgna Boyd

(Address) 524 N Stricker

15 Filed SEP 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to Sept 19, 1924

that I last saw her alive on Sept 17, 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) many yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral softening

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Geo M Settle, M. D.

9/20 1924 (Address) 2408 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lorenzo M.E. Whitehall Md.

DATE OF BURIAL: Sept 1924

20 UNDERTAKER: W. W. Cook

ADDRESS: 502 E Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should write mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90393

CERTIFICATE OF DEATH.

90 D 90393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Hanford ave ST.; 10 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kramer

(a) RESIDENCE NO. 937 Hanford ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip J. Kramer

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER Jacob Ambrosius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Buttner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. Philip J. Kramer
(Address) 937 Hanford ave

15 Filed ....., 19.... Burial Permit Clerk
P 2 0 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 20, 1924, that I last saw her alive on Sept 20, 1924, and that death occurred, on the date stated above, at 2-15 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilation Cardiac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Layman G. Abbott, M. D.

, 19 (Address) 1832 W. Cold 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loby Redeemer Cemetery	Sept. 22, 1924
20 UNDERTAKER	ADDRESS
Henry Hoen & Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should have CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90394 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 D 90394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. (Ward) 27

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Bland

(a) Residence No. 29 Summit Ave, Arlington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of ~~(or)~~ WIFE of Late V. H. Bland

6-DATE OF BIRTH (month, day and year) July 1 1844

7-AGE. 78 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Gloucester Co. Va.

PARENTS.

10-NAME OF FATHER, John Bland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Middlesex Co Va.

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Mr. Geo. R. Scott.

(Address) 29 Summit Ave Arlington

15- Filed SEP 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14 1924 to Sept. 19 1924

That I last saw him alive on Sept. 19 1924

and that death occurred, on the date stated above, at 3.35 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis, Myocarditis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Geo. B. Sybert M. D.

9/19. 1924 (Address) 1 Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Olive Grove Home Cemetery Gloucester Co. Va. DATE OF BURIAL. Sept. 20 1924

20-UNDERTAKER Henry Hooch Son ADDRESS 1301 E Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1745M D 90395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 60-001 D 90395

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. Oxford, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. —mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eva Smith

6 DATE OF BIRTH (month, day, and year) Aug. 15-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Nicholas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Elizabeth Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... Registrar

Robert P. Harrison, Burial Permit Clerk

P2 0 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924 to Sept 19, 1924, that I last saw him alive on Sept 19, 1924, and that death occurred, on the date stated above, at 10 50 a.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac failure secondary to exophthalmic goitre. Possible brain abscess

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? none

(Signed) Wm E Rienhoff Jr M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Del.	Sept 20 1924
20 UNDERTAKER Robt J Turner Inc	ADDRESS 1402 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90396 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 90396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St. 25th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm B. Oliver

(a) Residence No. Mount Hope Retreat St., 25th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Dead yrs. Never mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Mrs Oliver

6-DATE OF BIRTH (month, day and year) Jan 4-1859

7-AGE, 65 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ship Worker 6

(b) General nature of industry, business, or establishment in which employed (or employer) Ships - 5

(c) Name of employer.....

9-BIRTHPLACE (city or town) (?) (State or Country), England

PARENTS.

10-NAME OF FATHER, Thomas Oliver

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), England

12-MAIDEN NAME OF MOTHER Mary A. Brookshire

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), England

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Md -

15- Filed ..... Robert P. Harrison, Registrar.

P 2 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 17-1921, 19..., to Sept 15, 1924, that I last saw h Living alive on Sept 12, 1924, and that death occurred, on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Paresis - Complicated by Chr. Bronchitis -

(Duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Paretic Psychosis -

Acute (Duration) 3 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL, Sept 22 1924

20-UNDERTAKER, F. A. Kramer & Son ADDRESS 703 Hanover St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90397

CERTIFICATE OF DEATH.

90D 90397

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 Argyle Ave ST. 17 WARD)

2-FULL NAME Gertrude Brown Downs

(a) RESIDENCE NO. 1318 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Norman Downs

6 DATE OF BIRTH (month, day, and year): April 25 86

7 AGE — Years: 38 — Months: 11 — Days: 24 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book. Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Isaac Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Harrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Brown

(Address) 1318 Argyle Ave

15

Filed SEP 20 1924 15 Robert P. Herrlich Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1924

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1924, to Sept 18, 1924.

that I last saw her alive on Sept 17, 1924,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cor Mitral Regurgitation

2

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cor Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas F Claude M/D.

Sept 19, 1924 (Address) 1504 Mc Culloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn — DATE OF BURIAL: Sept 21 1924

20 UNDERTAKER: Chas H. Fraser Sons — ADDRESS: 1400 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90398

CERTIFICATE OF DEATH.

38 90398

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zimmerman

(a) RESIDENCE NO. 1147 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced

HUSBAND of Husband of Mary Zimmerman

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electroplater.

(b) General nature of industry, business, or establishment in which employed (or employer) 0816

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Golinghorst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, .19 Registrar

Burial Permit Clerk.

P 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18 1924

17

I HEREBY CERTIFY, That I attended deceased from August 21st 1924 to September 18th 1924, that I last saw h alive on September 18th 1924, and that death occurred, on the date stated above, at 6.05 p. m.

The CAUSE OF DEATH* was as follows:

Seminal vesiculitis (ars) and prostatitis

Cerebrospinal syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Harold Goodman. M. D.

.19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Crem	Sept 22 1924

20 UNDERTAKER ADDRESS Peter Nicolaus 2000 Eastern Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90399

CERTIFICATE OF DEATH.

D 90399

1-PLACE OF DEATH

City of BALTIMORE: (No. 5225 Reisterstown Rd. 27 Ward)

Registered No.

2-FULL NAME Nelson E Snyder

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 5225 Reisterstown Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Dora C. Snyder

6-DATE OF BIRTH (month, day and year) July 9th 1869

7-AGE, 55 yrs. 2 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Unknown Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Carrie Ness

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Dora C Snyder

(Address) 5225 Reisterstown Rd

15- Filed 192 Robert P. Harrison, Registrar.

P 20 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 18-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1924 to Sept 17 1924

that I last saw h~~im~~er alive on Sept 17 1924

and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Examination

(Signed) Wealthy A Cox M. D.

9/26, 1924 (Address) 2406 Forrest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Sept 22nd 1924

20-UNDERTAKER, George Schilling & Sons ADDRESS 1126 E Monument

Mortal Remains Civil

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90400

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 722 N. Gay St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary E. Groome

(a) Residence No. 122 N. Gay St St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 27th 1848

7-AGE, 76 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm L Groome

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Christiana Fuller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Anna C Groome

(Address) 722 N. Gay St

15- Robert P. Harrison, Registrar.

P 2 01924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-19-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1924 to Sept 19, 1924

that I last saw her alive on Sept 19, 1924

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Tubular Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

9/19, 1924 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem — DATE OF BURIAL, Sept 23rd 1924

20-UNDERTAKER, George Schilling & Sons — ADDRESS 1126 E Monument St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90401

100-D 90401

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3019 Arunah Ave ST., 16 WARD)

2-FULL NAME James N. Shawn

(a) RESIDENCE No. 3019 Arunah Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Avis Shawn

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Del.

PARENTS

10 NAME OF FATHER Benj W. Shawn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Mrs. Avis Shawn

(Address) 3019 Arunah Ave.

15 Filed ..., 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

SEP 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 1924, to Sept. 18, 1924, that I last saw h[illegible] alive on Sept 18, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank H. Hellen, M. D.

, 19 (Address) 1838 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 22, 1924
20 UNDERTAKER	ADDRESS
Wm Fickus & Son	Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90402

D 90402

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Corinne C. Mayer

(a) Residence No. Mt Hope Retreat St., 25 Ward Mobile-Ala.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 23-1886

7-AGE, 38 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mobile Ala

PARENTS.

10-NAME OF FATHER, Ferdinand F. Meyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mobile Ala

12-MAIDEN NAME OF MOTHER, Leonie Febraille

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mobile Ala

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Balto Md

15- Filed ..... 192.. Registrar.

Robert F. Harrison, Burial Permit Clerk.

P 2 D 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 19-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 12-1944 to Sept 19-1924

that I last saw h. alive on Sept 19-, 19.24,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart (Sudden)

Sudden (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Dementia Praecox

(Duration) 12 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Sept 19th 1924 (Address) Mt Hope Retreat Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mobile Ala

DATE OF BURIAL, Sept 20 19 24

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90403

CERTIFICATE OF DEATH.

D 90403

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Queen or Quinn

(a) Residence No. 502 W. Preston St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE,	If LESS than 1 day,
51 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D & O

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14-

(Informant) Municipal Hospital Records

(Address)

SEP 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-18-24

17- I HEREBY CERTIFY, That I attended deceased from 8-21, 1924 to 9-18, 1924

that I last saw h~~im~~ alive on 9-18, 1924

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension, Chronic Nephritis

(Duration) 9 yrs. 2 mos. (Hist.)

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude C. Dixon, M. D.

9-19, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 9/23/24, 19
W. Va. Veterans Cem.	
20-UNDERTAKER John N. Toadvine	ADDRESS 1827 Druid Hill Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90404

CERTIFICATE OF DEATH.

1-00 D 90404

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST. 70 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Boxer

(a) RESIDENCE No. 2024 Christian ST., ... WARD 21

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 30 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	11	20	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Solomon Boxer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Chosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 SEP 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 7, 1924, to Sept 20, 1924, that I last saw him alive on Sept 20, 1924, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidore D. Fry M. D.

Sept 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	9/21 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

NOTE—mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821-W. Lexington ST., 19 WARD)

2-FULL NAME Charles Anderson

(a) RESIDENCE No. 821-W-Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Anderson

6 DATE OF BIRTH (month, day, and year): 9/1865

7 AGE: Years 59 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): O & O

(c) Name of employer: unemployed

9 BIRTHPLACE (city or town) (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond

14 Informant (Address): Samuel H. Anderson Son Grey 841-W-Lexington

15 Filed SEP 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Sept 18, 1924, that I last saw him alive on Sept 18, 1924, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Walter J. Dodson M. D.

, 19 (Address) 168-W-Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 9/22/24

20 UNDERTAKER: David Easton

ADDRESS 916 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90406

CERTIFICATE OF DEATH.

188-003 D 90406

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gross Alms Sh on Shyett ST., 17 WARD)

2-FULL NAME Martha Wales

(a) RESIDENCE NO. 63 Hoop st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Mary Evans
(Address) 635 Gurley st

15 SEP 21 1924 ROBERT R. KRAUTER, Clerk
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Fractured Leg

(duration) ..... yrs. 9 hrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

9-20, 192 (Address) 1 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL W W Laubenstein Cem

DATE OF BURIAL 9/22/1924

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90407

CERTIFICATE OF DEATH.

113 ✓

D 90407

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 E Preston ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Soane

(a) RESIDENCE NO. 2013 E. Preston. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
		10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward M. Soane

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Brannan

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant (Address) Mrs. Margaret Brannan 2013 E Preston St

SEP 21 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1924, to Sept 20, 1924, that I last saw h alive on Sept 20, 1924, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Catarrhal Enteritis

(duration) 1 yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Anhemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William Traynor M. D.

1924 (Address) 1407 N Eighth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept. 22 1924

20 UNDERTAKER Henry Horak Son — ADDRESS 1301 E Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90408

CERTIFICATE OF DEATH.

100-001 D 90408

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

2-FULL NAME Charles J. Hentschel

(a) RESIDENCE NO. 1114 N. Eden St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July23/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Paul Hentschel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Christina Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14
Informant Paul Hentschel
(Address) 1114 N. Eden St.

15
SEP 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobular Pneumonia

(Autopsy at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. H. Carroll, M. D.
(Coroner.)
9/20/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 22 1924
20 UNDERTAKER	ADDRESS
Kenny Boucher & Son	1804 E. Eager St.

MUST NOT BE SIGNED BY UNDERTAKER. PHYSICIANS SHOULD HAVE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90409 ✓

D 90409

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1407 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Amelia C. Stew

(a) Residence No. 1407 Poplar Grove St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John P. Stew

6-DATE OF BIRTH (month, day and year) Sept 23 1857

7-AGE, 66 yrs. 11 mos. 27 ds. If LESS than 1 day ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stone

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob Crist

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Wilhelmina Batzer

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant).... John P. Stew

(Address) 1407 Poplar Grove St

13-

SEP 21 1924

ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEP 20 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to Sept 20, 1924, that I last saw him alive on Sept 19, 1924, and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows: Carcinoma (left. felon)

.....

.....

.....(Duration)....1..yrs.....mos..20..ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Appearance

(Signed)..... Irvin Stamp, M. D.

SEP 20 1924, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, London Park — DATE OF BURIAL, SEP 23 1924, 19....

20-UNDERTAKER, Leo W Little — ADDRESS 2700 EDMONDSON AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

11486 D 90410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84 D 90410

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Mary Darling

(a) RESIDENCE NO. 3404 Pershing Drive ST., ... WARD .....
(Usual place of abode) El Paso, Texas
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of Thomas Darling

6 DATE OF BIRTH (month, day, and year) Oct 20-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	1	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS
10 NAME OF FATHER William Wood
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER Kate Bateman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) La

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 SEP 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Sept 20, 1924, that I last saw h— alive on Sept 20, 1924, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:
Brain tumor - non-malignant

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pyelitis
(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Texas
Did an operation precede death? Yes Date of Sept 13, 1924
Was there an autopsy? Yes
What test confirmed diagnosis? Pathological Exam
(Signed) Warfield M Tyson M. D.
Sept 20 1924 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Orleans, La	Sept 21 1924
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Parrott

D 90411

HEALTH DEPARTMENT—CITY OF BALTIMORE

X65-002

D 90411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Druid Hill Ave ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen H. Parrott.

(a) RESIDENCE NO. 1725 Druid Hill Ave. ST. WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30 1858

7 AGE — Years: 66 Months: 3 Days: 18 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

887

9 BIRTHPLACE (city or town) (State or country) Newton N. C

PARENTS

10 NAME OF FATHER James Parrott

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Hickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catawba

14 Informant Veronica Parrott

(Address) 1725 Druid Hill Ave

15 Filed SEP 21 1924 ROBERT B. KRAUTER Registrar

Marital Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12 1924 to Sept. 18 1924

that I last saw him alive on Sept. 18 1924

and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood + Clinical Symptoms

(Signed) W. T. Carr Jr., M. D.

, 19 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: Sept 21 1924

20 UNDERTAKER: Samuel Wesley ADDRESS: 578

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90412

CERTIFICATE OF DEATH.

74-001 ✓ D 90412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4701 Harford Road ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Hall

(a) RESIDENCE No. 4701 Harford Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beverly T. Hall

6 DATE OF BIRTH (month, day, and year) Dec. 5-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	69	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary L. Bazar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Beverly T. Hall

(Address) 4701 Harford Road

15 SEP 21 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 19 24, to Sept 18, 19 24, that I last saw h[illegible] alive on Sept 15, 19 24, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows: apoplexy (Cerebral)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones M. D.

9/20, 1924 (Address) 1702 Hanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Sept. 22 1924

20 UNDERTAKER Horace F. Burgee ADDRESS 363 Fallsd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90413

1746 77

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

X 3 | D 90413

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Elizabeth Howard

(a) RESIDENCE NO. Abingdon ST., Harford Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. 29 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1924

7 AGE — Years | Months 1 | Days 29 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Millard Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucie Read

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

14 Informant: Records

(Address): Johns Hopkins Hospital

15 Filed SEP 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1924, to Sept 20, 1924, that I last saw h... alive on Sept 20, 1924, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Premature,

(duration) ... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute generalized miliary tuberculosis

(duration) ... yrs. 1 mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund B. Kemper, M. D.

9/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harford Co. | DATE OF BURIAL: Sept 21 1924

20 UNDERTAKER: Wm J. & Locke | ADDRESS: 1302 E. Mon...

N. B. WHILE PENALTY, WITHIN STATUTORY LIMITS, MAY BE IMPOSED FOR WILFUL OMISSION OR MISSTATEMENT OF INFORMATION, PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90414

CERTIFICATE OF DEATH.

1 x 90

D 90414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Lee Rhodes

(a) RESIDENCE NO. Severn Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Graze. Rhodes.

6 DATE OF BIRTH (month, day, and year) Oct 29th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	37.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Constable 961

(b) General nature of industry, business, or establishment in which employed (or employer) Ct. Annapolis

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Castle Pa.

PARENTS

10 NAME OF FATHER Peter S. Rhodes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Castle Pa.

12 MAIDEN NAME OF MOTHER Lilian Durban

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Castle Pa.

14 Informant George Meeks.

(Address) 1602 Harwich Ave.

SEP 21 1924

Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19/24 19

17

I HEREBY CERTIFY, That I attended deceased from 9/12/24, 19 ..., to 9/19/24 19 ..., that I last saw him alive on Sept 19, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio Vascular Disease. Acute Insufficiency Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Castle Pa. DATE OF BURIAL Sept 22nd 1924

20 UNDERTAKER Leo. G. Cook. ADDRESS North Stafford

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-10-24—M&T—1500 Bks.

D 90415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., V WARD)

2-FULL NAME Miss Margaret Lavin

(a) RESIDENCE NO. 324 E. 21st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cockeysville Md.

PARENTS

10 NAME OF FATHER Patrick Lavine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Lavine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Texas

14 Informant Patrick Lavin (Address) 324 E. 21st St.

15 SEP 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-5, 1924, to 9-20th, 1924, that I last saw her alive on Sept 20th, 1924, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

Tuberc. Kidneys (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Sept. 15, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Monninger, M. D.

Sept 20 1924 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Texas Md.

DATE OF BURIAL: Sept. 23 1924

20 UNDERTAKER: Richard F. Curley

ADDRESS: 108 Guilford Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U. S. A.

DO NOT TAKE

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90416 ✓ D 90416

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 N. Calvert ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Brown

(a) RESIDENCE. No. 2029 N. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William E. Brown

6 DATE OF BIRTH (month, day, and year) July 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Tammany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Fortune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm E. Brown

(Address) 2029 N Calvert St

15 Filed SEP 21 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Sept 19, 1924, that I last saw him alive on Sept 19, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? 2029 N Calvert

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McFeeley, M. D.

19 (Address) 707 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 21

20 UNDERTAKER E. A. Wiedefeld

ADDRESS 501 E 20

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90417

CERTIFICATE OF DEATH.

129 D 90417

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 Orkney Rd. (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard F Fitzgerald.

(a) RESIDENCE. No. 508 Orkney Rd. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Morris Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Maria Kelsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Miss Elizabeth Bypner
(Address) 5010 Kenyon Road

SEP 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1924, to Sept. 19, 1924, that I last saw h— alive on Sept. 19, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoess. M. D.

(Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	9/22/24
20 UNDERTAKER	ADDRESS
C. J. Tabler & Sons	1318 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90418

CERTIFICATE OF DEATH.

D 90418

REGISTERED NO.

1-PLACE OF DEATH Pronounced at

CITY OF BALTIMORE: (No. 1608 N. Caroline ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Robert Hugg

(a) RESIDENCE NO. 1608 N. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 17 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Lipp

6 DATE OF BIRTH (month, day, and year) March 2/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer American Oil Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Hugg

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Dawsey Ashley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Laura Hugg
(Address) 1608 N. Caroline St.

15 SEP 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 8 to 10 hrs. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) S. H. Pollitt, M. D.
(Coroner.)

Sept 20, 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 9/22 1924

20 UNDERTAKER Henry W. Mears & Son

ADDRESS N. Calvert

H. W. Mears & Son

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90419

CERTIFICATE OF DEATH.

38 D 90419

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 Millman ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William McDaniel

(Residence in Baltimore: No. Same 1638 Millman St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 29 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Labor

9-BIRTHPLACE, (State or Country), Balto Md-

PARENTS.

10-NAME OF FATHER, Edward McDaniel

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Maggie Henderson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W Henderson

(Address) 1502 E Monument St

15-

SEP 22 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1924, to Sept 19 1924, that I saw h... alive on Sept 19 1924, and that death occurred, on the date stated above, at 8.10 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Contributory (Secondary) Paralysis and Dilated Heart (Duration) ....yrs. ....mos. ....ds.

(Signed) R Young M. D.

9/21, 1924 (Address) 1724 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Sept 22, 1924

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

N.B. Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 90420

D 90420

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph Hospital ST., ... WARD)

2-FULL NAME Catherine Lennert

(a) RESIDENCE NO. 304 S. East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Lennert

6 DATE OF BIRTH (month, day, and year) Jan 25/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Packing House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer R.E.Roberts

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper ~~Krech~~ Wahl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lena Krech (daughter)
(Address) 304 S. East Ave

15 SEP 22 1924 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Collier, M. D. (Coroner.)

9/19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 22 1924

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Pract St

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90421 — 1-PLACE OF DEATH

D 90421 — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hartig

(a) Residence No. 504 E. 24th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1839

7-AGE 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- SEP 22 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-20-24

17- I HEREBY CERTIFY, That I attended deceased from 6-1, 1922, to 9-20, 1924, that I last saw h— alive on 9-20, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Carcinoma of Bowel (Supt)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Clarke G. Bruce, M. D.

9-20, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cemetery	Sept 22, 1924.
20-UNDERTAKER,	**ADDRESS**
George J. Smith	1532 Hollins St.

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

2-FULL NAME George Crump.

(a) RESIDENCE No. 824 W Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

133

D 90422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Crump.

6 DATE OF BIRTH (month, day, and year) May 24 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George W. Crump

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Lois E. Crump

(Address) 824 W Fayette St

15 Filed SEP 22 1924 ROBERT N. CHAUTEN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1924, to Sept. 21, 1924.

that I last saw him alive on Sept. 21, 1924.

and that death occurred, on the date stated above, at 12 30 Am.

The CAUSE OF DEATH* was as follows:

Papillaroma (Tumor) of Bladder

(duration) 2 yrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 19 and 20 1924

Was there an autopsy? no.

What test confirmed diagnosis? Exploratory Examination

(Signed) J B Whaley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scanton, Pa.	Sept 22 19 24
20 UNDERTAKER George A Smith	ADDRESS 1032 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90423

CERTIFICATE OF DEATH.

129 D 90423

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Walbrook Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Crosby.

(a) RESIDENCE NO. 3023 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud L. Crosby

6 DATE OF BIRTH (month, day, and year) Dec 27, 1863.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Otis Elevator Co.

9 BIRTHPLACE (city or town) (State or country) Irwinton Co. Pennsylvania

PARENTS

10 NAME OF FATHER George Crosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Julia Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jacob K. McCoy

(Address) 3023 Walbrook Ave

15 SEP 22 1924

ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 14th, 1924, to Sept 20th, 1924, that I last saw him alive on Sept 19th, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) L. L. Leady M. D.

Sept 20 1924 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Sept 23 1924
19 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90424

CERTIFICATE OF DEATH.

88 D 90424

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Fell Street ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna. Rozga

(a) RESIDENCE NO. 911 Fell Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Rozga

6 DATE OF BIRTH (month, day, and year) July 2 L898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry. Wrzesinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine. Makowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr John. Rozga

(Address) 911 Fell Street

15 ROBERT N. KRAUTH, Registrar

SEP 2 2 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29. 1924, to Sept. 17. 1924, that I last saw her alive on Sept. 15. 1924, and that death occurred, on the date stated above, at 915 P m.

The CAUSE OF DEATH* was as follows:

Acute Infectious Endocarditis

(Streptococcus Viridans)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) A. Flick, M. D.

Sept. 20 1924 (Address) 245 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem. Sep.	22 1924
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 90425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 759 W Franklin ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose B Brown.

(Residence in Baltimore: No. 759 W. Franklin St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, December 22, 1872.
(Month) (Day) (Year)

7-AGE, 51 yrs. 9 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evonia D. Brown

(Address) 759 W. Franklin St.

SEP 22 1924 Filed ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1924, to Sept 19 1924, that I saw h-- alive on Sept 19 1924, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral Regurgitation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. King M. D.

9-20..., 1924 (Address) 625 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel County — DATE OF BURIAL, 9/22/1924

20-UNDERTAKER Helen A. Holland — ADDRESS 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90426

OK D 90426

165 HK Forsuch Coroner Wds

CERTIFICATE OF DEATH

1-PLACE OF DEATH Vol. of America Hospt.

CITY OF BALTIMORE: (No. 418 W. Lexington St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wagner.

(a) RESIDENCE No. 835 Hollins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Female

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Girl

(b) General nature of industry, business, or establishment in which employed (or employer): not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER Aaron S. Wagner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Singer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) 835 Hollins St. Wm A. Wagner

Filed SEP 2 2 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1924, to Sept 21st, 1924, that I last saw her alive on Sept 21st, 1924, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Mercury Poisoning- Took 7 Bichloride Tablets (22½ grs)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia due to Anuria

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Vol. Am. Hospt.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) C. W. Didenhofer, M. D.

, 19 (Address) 418 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebron Parkdale — DATE OF BURIAL: 9/27/24

20 UNDERTAKER: Sol Lippman & Bro — ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90427

160 D 90427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 E. 24 ST., 12 WARD)

2-FULL NAME James H. Booth

(a) RESIDENCE NO. 405 E. 24 ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 26/24

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
			27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm. Jackson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Ernestine Booth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Ernestine Booth
(Address) 405 E 24th St.

Filed SEP 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

(Signed) John H. Brennan M. D.
(Coroner.)

Sept 22 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 22 1924
20 UNDERTAKER	ADDRESS
Wm. H. Elliott	Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90428

CERTIFICATE OF DEATH.

X 129 D 90428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (WARD)

2-FULL NAME Irene Quickley

(a) RESIDENCE NO. Long Green, Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Quickley

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 537

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Gibbs

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Charity Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: George Quickley

(Address) Long Green

15 SEP 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1924, to Sept. 20, 1924, that I last saw h alive on Sept. 20, 1924, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardiovascular Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Signs + Symptoms

(Signed) [illegible], M. D.

, 19 (Address) Union Mem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green

DATE OF BURIAL: Sept 22 1924

20 UNDERTAKER: Samuel Stanley

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 74-001 D 90429

1-PLACE OF DEATH D 90429 Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Adents

(a) Residence No. 1124 Low St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1868

7-AGE,	If LESS than 1 day,
56 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Haiti

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address) .....

SEP 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-19-24

17- I HEREBY CERTIFY, That I attended deceased from 3-11, 1924 to 9-19, 1924, that I last saw h[illegible]alive on 9-19, 1924 and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension, Cerebral Hemorrhage

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Fat

(Signed) Claude A. Wane, M. D.

9-19, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER,	ADDRESS,

UNIVERSITY OF MARYLAND

SEP 22 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

286

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90430 CERTIFICATE OF DEATH. 161-001 D 90430

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1106 mosher St., 16 Ward)

(If death occurred in a hospital or institution, gtve its NAME instead of street and number.)

2-FULL NAME. John Rethus

(a) Residence No. 1106 mosher St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 20, 1924

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day 4 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Pittsburgh Pa

PARENTS.

10-NAME OF FATHER. Jasper Rethus

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Somerset Co Pa

12-MAIDEN NAME OF MOTHER. Mary E Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). King George Co Va

14-

(Informant).....

(Address).....

15-

SEP 22 1924 ROBERT A. KRAUTH Registrar.

Special Permit Clerk.

1788

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 20, 1924

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1924 to Sept 20, 1924

that I last saw him alive on Sept 19, 1924

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

Premature birth (6 months)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. L. Bowery M. D.

, 19 (Address) 324 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19....
20-UNDERTAKER.	ADDRESS

LYING-IN HOSPITAL

SEP 20 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Pettres

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90431 B 90431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 Mosher St., 16 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pettres

(a) Residence No. 1106 mosher St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year): Sept 19-1924

7-AGE. (1924 Sept 19) yrs. mos. ds. If LESS than 1 day, 1 hrs. or 11 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jasper Pettres

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Jamaica W I

12-MAIDEN NAME OF MOTHER, Mary E Turner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), King Geo Co Md

14- (Informant) .....

(Address) JOHNS HOPKINS HOSPITAL

15- SEP 22 1924 ROBERT A. KRAUSE Registrar.

Asst Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1924 to Sept 19 1924

that I last saw him alive on Sept 19 1924

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

Prematurer Birth (6 months)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. McCleary, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
	..., 19..
20-UNDERTAKER.	ADDRESS

SEP 20 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90432 CERTIFICATE OF DEATH. X176 D 90432

1-PLACE OF DEATH Christs Institution Hospital Registered No.....

City of BALTIMORE: (No. 704 Eutaw St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hammond

(a) Residence No. Alexandria Va. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-Single, ✓ Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Since

6-DATE OF BIRTH (month, day and year)

7-AGE. 50 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Frederick Co. Md.

PARENTS.
10-NAME OF FATHER, —
11-BIRTHPLACE OF FATHER (city or town) (State or Country), —
12-MAIDEN NAME OF MOTHER, —
13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Dr C W K Kemp
(Address) 704 Eutaw St

15- SEP 2 1924 ROBERT A. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 19-24

17- I HEREBY CERTIFY, That I attended deceased from July 16- 1924 to Sept. 19- 1924
that I last saw him alive on Sept. 19 1924
and that death occurred, on the date stated above, at 12.50 P. m.
The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis & Dropsy (Duration) yrs. 10 mos. 5 ds.

18-Where was disease contracted if not at place of death? Delaware

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr C W Kemp M. D.
9-19 1924 (Address) 704 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND DATE OF BURIAL. SEP 20 1924

20-UNDERTAKER. [illegible] Board, [illegible] T. WOODALL ADDRESS

1785

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 D 90433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 90433

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lewis or Lewis

(a) Residence No. 1708 Thames St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15-Filed SEP 22 1924 ROBERT R. KRAUTH, Registrar.

Burial Permit Clerk.

1293

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-18-24

17- I HEREBY CERTIFY, That I attended deceased from 9-12, 1924 to 9-18, 1924 that I last saw him alive on 9-18, 1924 and that death occurred, on the date stated above, at 9:55 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & X-ray

(Signed) Claude O. Brown, M. D.

9-19-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER.	ADDRESS

UNIVERSITY OF MARYLAND

SEP 22 1924

Per. Wm. E. Woodall

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 Edmondson St., 16 WARD)

2-FULL NAME Mrs Ann Elizabeth Dorsey

(a) RESIDENCE NO. 1940 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. P. Dorsey

6 DATE OF BIRTH (month, day, and year) Sept 5 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	52	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER Samuel W. Harkerby

11 BIRTHPLACE OF FATHER (city or town) Cal. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo. P. Dorsey (Address) 1940 Edmondson Ave.

15 Filed SEP 22 1924 ROBERT A. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to Sept. 20, 1924, that I last saw h[illegible] alive on Sept. 18, 1924, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laryngeal tuberculosis (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? don't know.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum test.

(Signed) Martin F. Sloan, M. D.

9.22. 1924 (Address) 414 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL Sept. 1924

20 UNDERTAKER Wm J Pickner Sons ADDRESS North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90435

CERTIFICATE OF DEATH.

90 D 90435

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 15 Rockdale St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James L. Walmsley

(a) Residence No. 15 Rockdale St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma

6-DATE OF BIRTH (month, day and year) March 14, 1843

7-AGE. 81 yrs. 6 mos. 7 ds. | If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)..... 013

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER Robert Walmsley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Harriet Gooding

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Martha Myers

(Address) 15 Rockdale Ave

15- ROBERT H. KRAUTER,

SEP 22 1924 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from ....., 19 22 to Sept 21, 19 24

that I last saw h.. alive on Sept 20th 19 24

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

Mitral Regurgitation

.....(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Gustave Fritz M. D.

9/21, 19 24 (Address) Eureka

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore	Sept 24 19 24
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1737 Eager

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

or.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1 PLACE OF DEATH
(a) CITY OF BALTIMORE: (No. Gatch Memorial Church, Belair Road ST., WARD)
(b) COUNTY OF BALTIMORE: (No. ..... ST., ... WARD .....)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James G. Walmsley

3 (a) RESIDENCE NO. 15 Rockdale Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

If married, widowed, or divorced
(Give) HUSBAND of
WIFE of Emma R. Walmsley

6 DATE OF BIRTH (month, day, and year) March 14/1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	81	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkton Md.

10 NAME OF FATHER Robert Walmsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) British Isles?

12 MAIDEN NAME OF MOTHER Harriet Gooding McCauley?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant Mrs. C. Oscar Myers
(Address) 15 Rockdale Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Senility (duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] (Coroner), M. D.
9/22/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms that it may be properly tion is very important. See ins[illegible] on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

D 90436 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001
D 90436

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Hollins St ST., 18 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lola A. Mitchell,

(a) RESIDENCE No. 817 Hollins St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard G Mitchell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Va

PARENTS

10 NAME OF FATHER Henry Tolzhugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Downman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs Adelyne D Mitchell 817 Hollins St

15 Filed SEP 22 1924 ROBERT R. KNAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924, to Sept. 21, 1924, that I last saw her alive on Sept. 21, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis, etc.

(Signed) J. Thos Worton, M. D.

9/21/24. (Address) 888 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Confederate Cem Fredericksburg Va

DATE OF BURIAL Sept 23 1924

20 UNDERTAKER Coleman & Lord

ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90437

CERTIFICATE OF DEATH.

100 90437

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mc Sheffrey

(a) Residence No. 332 Bruce St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 8/14/24

7-AGE. ..yrs. 8 mos. —ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, John Mc Sheffrey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). do not know

12-MAIDEN NAME OF MOTHER, do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) do not know

14- (Informant) M. Mc Sheffrey

(Address) 332 Bruce St.

15- SEP 22 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/21/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 18th 1924 to Sept 21st 1924, that I last saw h[e] alive on Sept 21st 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Rickets - Malnutrition

(Duration) ....yrs. 4 mos. ....ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. T. Owens M. D

9/21, 1924 (Address) 864 Cathedral St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Sept 22
20-UNDERTAKER Joseph F. Cowan & Son Geo F. Cowan	ADDRESS 901 Cathedral St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90438

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 807 W. Cross St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Raymond Heffernan

(a) Residence No. 867 W. Cross St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 31 1924

7-AGE, ...yrs. 3 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, George T. Heffernan

11-BIRTHPLACE OF FATHER (city or town) Jersey City (State or Country),

12-MAIDEN NAME OF MOTHER, Marie Kelly

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) George T. Heffernan

(Address) 867 W. Cross St

15- SEP 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 20, 1924,

that I last saw h.....alive on....., 19.....

and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

.....(Duration).....yrs. 10 mos.....ds.

CONTRIBUTORY (Secondary) Endocarditis

.....(Duration).....yrs. 3 mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Edw. Sonnborn, M. D.

9/24, 192.. (Address) 517 Loop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Sept 22, 1924
20-UNDERTAKER, James Dignan & Son	ADDRESS 1000 S. Pacael

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90439

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Krauski

(a) RESIDENCE NO. Laurel, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or.....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard County Md.

PARENTS

10 NAME OF FATHER: Martin Krauski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Arthur Krauski

(Address) Laurel Md.

SEP 22 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 24, to Sept 21, 19 24, that I last saw him alive on Sept 21, 19 24 and that death occurred, on the date stated above, at 11.00 P m.

The CAUSE OF DEATH* was as follows:

Abdominal abscess

7

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 1, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) 111 Shutter, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem Md	9-23rd 1924
20 UNDERTAKER	ADDRESS
Erb Hart	115 E West St

N. B.—WRITE PLAINLY WITH UNFADING INK. THIS CERTIFICATE, WHEN COMPLETED, SHOULD BE PRESERVED BY THE FAMILY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

14233

D 90440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 90440

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Sterling

(a) RESIDENCE NO. 1905 W. North Ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Abe Sterling

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Parsonnet

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) U.S.

14 Informant Hosp Johns Hopkins (Address)

15 SEP 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Sept 22, 1924, that I last saw him alive on Sept 22, 1924, and that death occurred, on the date stated above, at 6 50/60 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edmund H. Kemper M. D.

9/22, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemet	9-22- 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Baer

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90441

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

D 90441

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 N. Patterson Pk ave ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Sirulnik

(Residence in Baltimore: No. 429 N. Patterson Pk ave St.; ..... yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: (Month) Jan (Day) Com, 1901 (Year)

7-AGE: 23 yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

037

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Mendel Unger

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Sarah —

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Levis

(Address) 1439 E Balt St

15- SEP 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 22nd (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1924, to, Sept 22nd 1924, that I saw h-er alive on Sept 22nd 1924, and that death occurred, on the date stated above, at 6:30a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs ..... mos. ..... ds.

(Signed), H. J. Sankin M. D.

[Address] 1192 N. Mellvorn

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Westminster

DATE OF BURIAL: Sept 22 1924

20-UNDERTAKER: Jack Levis

ADDRESS: 1439 E Balt St

Spec.—1-10-21—M&T—1500 Bks.

Ortain
12 E 25

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90442

74-001 D 90442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4031 Bonner Rd St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia M Armeling

(a) RESIDENCE NO. 4031 Bonner Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Armeling

6 DATE OF BIRTH (month, day and year): Nov 2 1850

7 AGE — Years: 73 — Months: 10 — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Kempel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Agnes Lenzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: George S Armeling

(Address) 4031 Bonner Road

Filed SEP 22 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1922, to Sept 21, 1924, that I last saw h[illegible] alive on Sept 17, 1924 and that death occurred, on the date stated above, at — a m.

The CAUSE OF DEATH* was as follows:

Senile —

Arteriosclerosis

(duration) 2 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) probably Apoplexy

(duration) yrs. a few hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. A Fair, M. D.

9/21/1924 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Sept 23 1924

20 UNDERTAKER: Jno Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90443

CERTIFICATE OF DEATH.

186-008

D 90443

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital (St.) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Hill

(a) RESIDENCE NO 1817 E. Franklin St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Hill

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Gansen

13 BIRTHPLACE OF MOTHER (city or town) Dead to Me
(State or country)

14 Informant Mrs. Ida Hill
(Address) 1817 E. Franklin

SEP 22 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an On Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said On Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: 1st 4 hrs 2d 6 hrs Ribs Right Side Fractured Shock (duration) 9 hours

CONTRIBUTORY (Secondary) Struck by Automobile (duration) yrs. mos. ds.

(Signed) ... M. D.
(Coroner.)

Sept 24 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park C	Sep 23 1924
20 UNDERTAKER W M Routson	ADDRESS 2238 N Monroe

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90444

CERTIFICATE OF DEATH.

D 90444

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1315 N Montford Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... August Bena

(a) Residence No. 1315 N. Montford St., 8 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Victorine Bena

6-DATE OF BIRTH (month, day and year) Sept 7 1867

7-AGE, 67 yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Glass Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Alsace France

PARENTS:

10-NAME OF FATHER, August Bena

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER Audrey Jacquesall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), France

14- (Informant) Victorine Bena

(Address) 1315 N. Montford Ave

15- Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

SEP 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1924 to Sept 21 1924

that I last saw him alive on Sept 19 1924

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Phthisis

(Duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Herzog M.D., M. D.

Sept 21, 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL, Sept 23, 1924

20-UNDERTAKER George L. Schmidt ADDRESS 1501 Eutaw Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90445

CERTIFICATE OF DEATH.

90 D 90445

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maria Nash

(a) Residence No. Preston & Valley Sts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ephraim Nash

6-DATE OF BIRTH (month, day and year) Unknown 1860

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Johns Crane,

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Eliza Coughlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant) Sister Florence

(Address) Preston & Valley

15-

SEP 22 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 22 '24

17- I HEREBY CERTIFY, That I attended deceased from No record 19.. to 19..

that I last saw h. Ex alive on Sept 21, 1924

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Sept 22, 1924 (Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Sept 25, 1924

20-UNDERTAKER, H. C. Wiedefeld — ADDRESS 91 Greenmount Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90446

CERTIFICATE OF DEATH.

118-062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael E. Ward

(a) RESIDENCE NO. 708 E Chase ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57				

8 OCCUPATION OF DEACESED

(a) Trade, profesalon or particular kind of work 061

(b) General nature of industry, business, or establishment in which employed (or employer) Policeman,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hugh Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Record

15 Robert P. Harrison, Registrar

P 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/1924

17 I HEREBY CERTIFY, That I attended deceased from 9/8/24, 19.... to 9/21/24, that I last saw h alive on 9/21/24, and that death occurred, on the date stated above, ... m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus
Hypertrophied Prostate

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9/13/24

Was there an autopsy? Yes

What test confirmed diagnosis Clinical & Autopsy

(Signed) L. W. Dalbey M.D.

19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 25 1924

20 UNDERTAKER H. C. Wiedefeld & Son — ADDRESS Greenmount Ave.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ERASURES or illegible mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90447

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 E. Federal St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Hagen

(a) Residence No. 1822 E Federal St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Hagen

6-DATE OF BIRTH (month, day and year) Sept 9. 1879

7-AGE. 65 yrs. mos. 13 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer) Wagons

(c) Name of employer Frances D. [illegible]

9-BIRTHPLACE (city or town) Catonsville (State or Country), Md

PARENTS.

10-NAME OF FATHER, Fredrick Hagen

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country).

14- (Informant) Mrs Bertha Hagen

(Address) 1822 E Federal St

15-

Filed Sep 22 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 22 1924

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to Sept 22 1924

that I last saw him alive on Sept 19 1924

and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Jno F Frohn M. D

9/22, 1924 (Address) 1823 E Madison St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Salem Lutheran Catonsville — DATE OF BURIAL. Sept 24, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Fayette

SEP 22 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90448

CERTIFICATE OF DEATH.

× 124 D 90448

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Katie Urban

(a) RESIDENCE No. Taylor Avenue ST., Parkville WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Urban

6 DATE OF BIRTH (month, day, and year) Nov. 15th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Budapest Hungarian

PARENTS

10 NAME OF FATHER Jacob Staudinger

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Hungarian

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Hungarian

14 Informant University Hosp. Records (Address)

15 Filed Robert F. Harrison, Registrar

SEP 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 20, 1924.

that I last saw h.r alive on Sept 20, 1924.

and that death occurred, on the date stated above, at 7 30 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic congestion.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute cholecystitis.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Sep. 19

Was there an autopsy? No

What test confirmed diagnosis? operation & autopsy

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept. 23, 24
20 UNDERTAKER	ADDRESS
Fred'k Lasalmo Sons	Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... should be stated EXACTLY. PHYSICIANS ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90449

D 90449

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Cathedral ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Fraser

(a) RESIDENCE NO. 609 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed~~, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Josephine Fraser

6 DATE OF BIRTH (month, day, and year) Nov 5th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Late HBM Consul

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Gilpin Fraser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Helen Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mr Penniman (Address) 609 Cathedral St

15 Filed Sept 23 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 22 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 1919, to Sept. 22, 1924, that I last saw him alive on Sept. 22, 1924, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Hypertension

Cerebral hemorrhage - Hemiplegia

Followed by other cerebral hemorrhages

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage followed by complete unconsciousness (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis? Physical examination

(Signed) Frank T. Smith M. D.

Sept 23, 1924 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Sept 23 1924

20 UNDERTAKER Henry H Jenkins Sons Co — ADDRESS Eden & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec– 12-23-21– E.B.R.S.—400 Blks.

D 90450

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-001

D 90450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1803 Braddish Ave St. ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Baker

(a) Residence No. 1803 Braddish Ave St. ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Baker

6-DATE OF BIRTH (month, day and year) April 6 1880

7-AGE. 44 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Geo H Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Monroe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Irene Baker

(Address) 1803 Braddish Ave

15-

SEP 22 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sep 20 1924

17- I HEREBY CERTIFY, That I attended deceased from 5/1 1924 to 9/20 1924 that I last saw him alive on 9/20/24 19.... and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) .... yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. D. Baker M. D.

9/22 1924 (Address) 1803 Braddish Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Church DATE OF BURIAL. Sept 23 1924

20-UNDERTAKER. CHENOWETH & SON ADDRESS 1417 CHESTNUT AVE

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90451 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1608 N Lexington St., 19 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Taylor Collins

(a) Residence No. 1608 N Lexington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 17 1923

7-AGE. yrs. 1 mos. 4 ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Alfred C Collins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER. Rose E Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Alfred C Collins

(Address) 1608 N Lex St

15- Filed SEP 23 1924 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1924, to Sept 21 1924, that I last saw her alive on Sept 21 1924, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pleo Colitis

(Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos R Schaefer, M. D.

Sept 24, 1924 (Address) 1503 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Sept 23 1924
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 N Mills St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90452

Registered No. D 90452

1-PLACE OF DEATH

City of BALTIMORE: (No. 2027 E. Preston Street St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Beck

(a) Residence No. 2027 E. Preston Street St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm. H. Beck

6-DATE OF BIRTH (month, day and year): Mar. 17, 1857

7-AGE: 67 yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: John T. Schneider

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Hessen, Germany

12-MAIDEN NAME OF MOTHER: Anna E. Ritter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): William H. Beck

(Address): 2027 E. Preston St.

15- FILED SEP 23 1924 ROBERT R. KRAUTH, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10th, 1924, to Sept. 20th, 1924, that I last saw her alive on Sept. 20th, 1924, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation.

(Signed) Wm. Conrad Bode, M. D.

9-20, 1924 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Pk Cem. DATE OF BURIAL, 9/24/24

20-UNDERTAKER: Joseph B. Cook ADDRESS 1038 W. Balto St.

INSTRUCTIONS TO PHYSICIANS: Should be carefully filled out EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90453

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1512 Druid Hill Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Hudnell

(a) Residence No. 1512 Druid Hill Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced (write the word) Single

6-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9-19-24

7-AGE. ....yrs. ....mos. 3 ds.

If LESS than 1 day, ...hrs. or. ....min.

8-OCCUPATION OF DECEASED none

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Harry Hudnell

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Lancaster Co., Va.

12-MAIDEN NAME OF MOTHER, Celestie Perry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Celestine Hudnell

(Address) 1512 Druid Hill Ave

15- Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-22-24

17- I HEREBY CERTIFY, That I attended deceased from 9-19- 19 24 to 9-22 19 24

that I last saw h[illegible] alive on 9-21 19 24

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) M. Alexander Nowey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cem

DATE OF BURIAL, 9/23/24

20-UNDERTAKER, Dan'l Carson

ADDRESS 710 Fremont Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Coleman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90454

CERTIFICATE OF DEATH.

D 90454

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Martha A Coleman St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 854 W Lexington St

(a) Residence No. 854 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Va (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant): Lee Williams

(Address): 854 W Lexington

15- SEP 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/22/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 19 24, to Sept 22, 19 24, that I last saw h alive on Sept 20, 19 24, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Intermittent

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem Va — DATE OF BURIAL, 9/24/1924

20-UNDERTAKER: David Easton — ADDRESS 914 Park Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90455

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 918-E. Madison ST., 11 WARD)

2-FULL NAME. Richard Harrison

(a) RESIDENCE. No. 918-E. Madison ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 17, 1923

7 AGE — Years: 1 — Months: 1 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Agnes Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Agnes Harrison 1534 Druid Hill Ave

15 Filed ..... 19 .....

SEP 23 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924, to Sept 21, 1924, that I last saw h[illegible] alive on Sept 21, 1924, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows: Contusion Brain - Probably complicated with intoxication

(duration) yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem examination

(Signed) H. Garland Mitchell M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md Cemetery	Sept 23 1924
20 UNDERTAKER	ADDRESS
Mrs R A Ellis	Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90456

CERTIFICATE OF DEATH.

101-001

B 90456

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1158 Longwood ST. 16 WARD)

2-FULL NAME Marie Hamilton Lineweaver

(a) RESIDENCE. No. 1158 Longwood ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter L. Lineweaver

6 DATE OF BIRTH (month, day, and year) July 30 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. H. Cox

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Ann Sims

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Mrs. W. F. Wagner (Address) 1158 Longwood

SEP 2 3 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18 1924 to Sept 20 1924 that I last saw h[e] alive on Sept. 20 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark, M. D.

(Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 23rd 1924

20 UNDERTAKER H. C. Browning & Son

ADDRESS 1711 E. Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90457

CERTIFICATE OF DEATH.

100-001

D 90457

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Smith

(a) Residence No. 1518 E. Pratt st. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1884

7-AGE.	If LESS than 1 day.
40 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework 10 01

(b) General nature of Industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, Daniel Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Alice Mccullough

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed ROBERT S. KRAUTER, Registrar.

SEP 23 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1924 to Sept. 22, 1924, that I last saw h. 6r alive on Sept. 22, 1924, and that death occurred, on the date stated above, at 7.40A m.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism; delirium tremens. Terminal broncho-pneumonia. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. F. White, M. D.

9-22-, 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Sep 24, 1924
20-UNDERTAKER.	ADDRESS
Wondell Kyper & Son	378 N

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90458

D 90458

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Cornell ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora L Handy,

(Residence in Baltimore: No. 613 Cornell St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col	Married

6-DATE OF BIRTH, March 12, 1882
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 5 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Francis Williams

11-BIRTHPLACE OF FATHER (State or Country). Illinois

12-MAIDEN NAME OF MOTHER Mary J. Laurence

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore County Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Mason

(Address) Belleview, Md.

15- SEP 23 1924 ROBERT R. KRAUTER
(Date) 191.. Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1921, to Sept 20 1924, that I saw h er alive on Sept 20 1924, and that death occurred, on the date stated above, at 11 a, m.

The CAUSE OF DEATH* was as follows:

Ch Pulmonary Tuberculosis

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas Lawrence M. D.

9/22/24, 191.. (Address) 122 W Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL, Sept 23., 1924.

20-UNDERTAKER Jas Geo H Hooper

ADDRESS 406 N Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

174520 D 90459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 90459

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 18 WARD)

2-FULL NAME Albert Hill

(a) RESIDENCE NO. 12 S Schroeder St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Sept 2, 1924

7 AGE — Years — Months — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): #

(c) Name of employer: #

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joel Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Francis Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 SEP 23 1924 ROBERT A. KRAUTER, Registrar

Registrar's District

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924, to Sept 17, 1924.

that I last saw h— alive on Sept 17, 1924,

and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 2 wks.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter D. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner of Health, — ADDRESS SEP 23 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90460 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90460

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2745 Winchester St. (St.) 16 (WARD)

2-FULL NAME Elizabeth Mary Wallblich

(a) RESIDENCE NO. 2745 Winchester St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: W White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Charles Wallblich

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 50 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS
10 NAME OF FATHER: Ernst Hammerdan.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 NAME OF MOTHER: Dorothea
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Wallblich
(Address) 2745 Winchester

Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 1 1924, to Sept 20 1924,
that I last saw h alive on Sept 20 1924,
and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:
Recurrent Carcinoma of Liver Stomach & Lungs
Intestines.
(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Carcinoma Uteri
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore
Did an operation precede death? Yes Date of Sept 1922
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Wm T3 Lemmon M. D.
9/23/24 (Address) 918 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer
DATE OF BURIAL: Sept 25 1924

20 UNDERTAKER: M Fabes & Sons
ADDRESS: 1918 North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90461

D 90461

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number) Wash. D.C.

2-FULL NAME James Croatic

(a) RESIDENCE No. St Vincents Orphanage WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Croatic

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 SEP 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Sept 20, 1924, that I last saw h alive on Sept 20, 1924, and that death occurred, on the date stated above, at 7-45 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and Vomiting

(duration) ..... yrs. ..... mos. 1 da. ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? St Vincents Infant Asylum

Did an operation precede death? Yes Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H Kemper, M. D.

9/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Sept 23 1924

20 UNDERTAKER Martin Funeral Home

ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1006 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90462

CERTIFICATE OF DEATH.

B 90462

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3723 Mt Pleasant Ave ST. WARD)

2-FULL NAME John C Schreiber

(a) RESIDENCE. No. 3723 Mt Pleasant ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/21/24.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Maria A Phemmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Schreiber
(Address) 3723 Mt Pleasant ave

SEP 23 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22/1924

17

I HEREBY CERTIFY, That I attended deceased from 9/21, 1924 to 9/22, 1924

that I last saw h[illegible] alive on 9/22, 1924

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Atelectasis — Convulsions (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright L. Adler, M. D.

9/22/1924 (Address) 3373 E. Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	23 1924

20 UNDERTAKER ADDRESS

John C. Miller 3019 E Monument St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90463

CERTIFICATE OF DEATH.

101-001 D 90463

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 545 Kirby Lane (ST.) 20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Cathreine Johnson

(a) RESIDENCE No. 545 Kirby Lane ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stanley Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Estell Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Stanley Johnson
(Address) 545 Kirby Lane.

SEP 3 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22. 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21 19 24 to Sept. 22 19 24

that I last saw her alive on Sept. 21 19 24

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Nothing

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt Auburn Cemetery

DATE OF BURIAL 9-23 1924

20 UNDERTAKER Joseph A. Lively

ADDRESS 151 Wentworth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90464

CERTIFICATE OF DEATH.

90 D 90464

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 526 E. 13th St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Lackey

(a) Residence No. 526 E. 13th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Lackey

6-DATE OF BIRTH (month, day and year) Oct 10, 1866

7-AGE. 57 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Paper x Whitey
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, William Lackey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mary Lackey
(Address) 526 E. 13th St.

15- Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 21/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924 to Sept 21, 1924 that I last saw h alive on Sept 20, 1924 and that death occurred, on the date stated above, at 2.35 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis + Uremia —

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis + Chronic Valvular heart disease (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) C. A. Reifschneider, M. D.

9/22 1924 (Address) 2439 Fairmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Sacred Heart Cem	Sept 24, 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Mert St.

N. B.—WRITE PLAINLY, with unfading ink. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Blks.

D 90465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90465

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Eighth st near 2nd St., Fairfield Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Locker

(a) Residence No. Eighth st near 2nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 16 1904

7-AGE. yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Fairfield

PARENTS.

10-NAME OF FATHER. Leo. Locker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Switzerland

12-MAIDEN NAME OF MOTHER. Anna Snider

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Anna Locker

(Address) Eighth st near 2nd

15- SEP 2 3 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/21/24

17- I HEREBY CERTIFY, That I attended deceased from 9/18/24, 19.., to 9/21/24, 19.., that I last saw h.. alive on 9/21/24, 19.., and that death occurred, on the date stated above, at 8.45 m.

The CAUSE OF DEATH* was as follows:

Ilio Colitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Three of Ilio Colitis

(Signed) Walter C Bacon M. D

9/22/24 (Address) 100 E 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Sept 23 19 24

20-UNDERTAKER. F A Kranse & Son ADDRESS 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—This Certificate is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Edward. N. Carpenter

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90466

CERTIFICATE OF DEATH.

49 D 90466

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. W. Carpenter

(a) RESIDENCE NO. 705 Lemmon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16, 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Custom inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER E.W. Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Virginia Seebad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant (Address) E. W. Carpenter

15 Filed SEP 23 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 24

17

I HEREBY CERTIFY, That I attended deceased from May 30, 19 24, to Sept 21, 19 24

that I last saw him alive on Sept 21, 19 24

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. mos 4 wks ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) H. Kentopp M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Sept 23, 19 24

20 UNDERTAKER Harry H. Lichtzicl — ADDRESS 1540 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90467 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90467

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #3 Cherry Ave ST., Belvedere 96 WARD)

2-FULL NAME Thomas W. Bussey

(a) RESIDENCE No. 3 Cherry Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Octavia A. Bussey

6 DATE OF BIRTH (month, day, and year) April 6, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md

PARENTS

10 NAME OF FATHER Edward Bussey

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Julia Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md

14 Informant Bessie A. Bussey (Address) 3 Cherry Ave

15 Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/23/1923, to 9/21/1924,

that I last saw h— alive on 9/20/24, 1924

and that death occurred, on the date stated above, at 5:42 A. m.

The CAUSE OF DEATH* was as follows:

Hypostasis
Chr. Diff. Nephr.
Art. Sclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Terry, M. D.

9/24, 1924 (Address) 410 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Ignatius, Harford, Harford Co	Sept 24 1924

20 UNDERTAKER Henry H. Mentzel Jr ADDRESS 1529 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90468

CERTIFICATE OF DEATH.

102 D 90468

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Mc Culloh ST. 14 WARD)

2-FULL NAME James H. Longstreet

(a) RESIDENCE: No. 1601 Mc Culloh ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary A. Longstreet

6 DATE OF BIRTH (month, day, and year) April - 62

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Drayman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Jas. H. Longstreet

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Sadie Gryglasky

(Address) 1601 Mc Culloh St

15 SEP 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Sept 20 24~~ Sept 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 20, 1924, that I last saw h[illegible] alive on Sept 18th, 1924, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) General Debility

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo W. Hemmeter, M. D.

9/13, 1924 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Hebron	Sept 24 1924
20 UNDERTAKER	ADDRESS
Sam H. Grace & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90469

CERTIFICATE OF DEATH.

124 D 90469
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Clifton Ave ST., 15 WARD)

2-FULL NAME Julia A. Snyder

(a) RESIDENCE NO. 1603 Clifton Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur H. Snyder

6 DATE OF BIRTH (month, day, and year): Dec 11-1872

7 AGE — Years: 52 — Months: 9 — Days: 10 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jacob Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Arthur H. Snyder
(Address) 1603 Clifton Ave

15 SEP 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1924

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to Sept 21, 1924.

that I last saw her alive on Sept 20 1924

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Hunter M. D.

(Address) 1 y Wendover Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Sept 23 19

20 UNDERTAKER: H. G. Tuchner & Son — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6231 York Road ST., 27 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Louise Humphreys

(a) RESIDENCE No. 6231 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry B. Humphreys

6 DATE OF BIRTH (month, day, and year) Oct. 16.1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Sophie Winholz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry B. Humphrey

(Address) 6231 York Road

15 Filed SEP 23 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 1924

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1924, to Septemb 21, 1924, that I last saw her alive on Septemb 21, 1924, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral & Aortic Insufficiency

Chronic Cholecystitis

(duration) 17+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. W. Bishop, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 24 1924

20 UNDERTAKER Wm. J. Tickner & So

ADDRESS Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90471

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 90471

Registered No.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5 E. Biddle St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Rankin Brown

(a) Residence No. 5 E. Biddle St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Brown

6-DATE OF BIRTH (month, day and year) Nov 1861

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John T. Wood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Isabella H Sewell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Katy Corn Wood

(Address) 5 E. Biddle St

SEP 23 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) September 1924

17- I HEREBY CERTIFY, That I attended deceased from 1924, 19.. to Sept 22, 1924, that I last saw h.. alive on Sept 21, 1924, and that death occurred, on the date stated above, at 1.30 P. m. The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Arthritis inflet

(Duration) yrs. 22 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Lybstant M. D.

9-23, 1924 (Address) 211 W. Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Dulaney Mount Cem

DATE OF BURIAL, Sept 24, 1924

20-UNDERTAKER, John O. Mitchell

ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90472

17462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90472

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME John E. Brooks

(a) RESIDENCE No. 1506 Mosher St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Read (Address) JOHNS HOPKINS HOSPITAL

SEP 23 1924 HOSTER R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1924, to Sept 20, 1924,

that I last saw him alive on Sept 20, 1924,

and that death occurred, on the date stated above, at 4 55 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor Tuberculosis

Pulmon. Tuberculosis 2d.

(duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) James B. Marten, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 24 1924

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N. Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—2-12-23—M&T—100 Bks.

D 90473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 90473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 N Stricker ST., 15 WARD)

2-FULL NAME Andrew Simms

(a) RESIDENCE No. 1336 N Stricker ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Simms

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 54 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Oyster man
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West river Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Mary Simms
(Address): 1336 N. Stricker St

15 SEP 23 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Gustavus Bode, M. D.
(Coroner.)

Sept 23 1924 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Sept 23 24

20 UNDERTAKER: Samuel Krusen Jr | ADDRESS: 1308

N.B.—WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 90474

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Evergreen Hospital ST., Gold Spring Lane WARD)

2-FULL NAME Frank Ruckele

(a) RESIDENCE No. Evergreen Hospital ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Ruckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Agnes Buick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas Mo.

14 Informant Frank Ruckel
(Address) Evergreen Hosp

15 SEP 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Gi

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
1924 (Address) 532 Rolandv

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilton Kansas Mo	Sept 23 1924
20 UNDERTAKER E. A. Wiedefeld	ADDRESS 501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

William Kaczarowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90475

CERTIFICATE OF DEATH.

9 D 90475

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 N Linwood ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kaczarowski

(a) RESIDENCE NO. 129 N Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): aug 17-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt City

PARENTS

10 NAME OF FATHER: Michael Kaczarowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Pramilla Lupka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Michael Kaczarowski

(Address): 129 N Linwood ave

15 SEP 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1924, to 9/22, 1924,

that I last saw him alive on 9/21, 1924

and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Pertussis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Raymond S Kunkel, M. D.

1924 (Address) 3325 Patapsco

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Hamilton.	Sept 23 1924
20 UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90476

HEALTH DEPARTMENT—CITY OF BALTIMORE

+38

D 90476

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hosp ST., 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Brownstein

(a) RESIDENCE NO. 111 N Gallington ave ST., WARD Newport News Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Abraham Brownstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Benj
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Baltimore St

Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1924, to 9/22, 1924, that I last saw he r alive on 9/22, 1924, and that death occurred, on the date stated above, at 9.50 p.m.

The CAUSE OF DEATH* was as follows:
Aortic & Mitral Regurgitation
Chronic Nephritis - Hypertension
Chronic Bronchitis & Emphysema
Lues (duration) √ yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? √ Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) A Stolerman M. D.
, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Shrs Md DATE OF BURIAL 9/23 1924

20 UNDERTAKER Jack Lewis 1439 E Baltimore ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90477

1-PLACE OF DEATH D 90477

City of BALTIMORE: (No. 1407 N. Mount St., 15 Ward)

Registered No. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Adams

(a) Residence No. 1407 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	Negro.	✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) 9/22/24

7-AGE, ~~Hours~~

0 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore City (State or Country),

PARENTS.

10-NAME OF FATHER, George Diggs ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Mary Adams.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant)

(Address)

15- Filed SEP 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-22-24

17- I HEREBY CERTIFY, That I attended deceased from 9-22, 1924 to 9-22 1924

that I last saw h. alive on 9-22 1924

and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

asphyxia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Papara M. D

9-22 1924 (Address) 1702 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
HOPKINS HOSPITAL	19
20-UNDERTAKER.	ADDRESS

SEP 23 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-90

[7.95]

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90478

CERTIFICATE OF DEATH.

24 129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 E. Hamburg St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME G. Frederick Fleury

(a) Residence No. 116 E. Hamburg St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fleury

6-DATE OF BIRTH (month, day and year) Aug. 25 1880

7-AGE. 44 yrs. 0 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Huckster

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS:

10-NAME OF FATHER, J. Frederick Fleury

11-BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12-MAIDEN NAME OF MOTHER, Sophia Myers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md.

14- (Informant) Mrs. Fleury

(Address) 116 E. Hamburg St

15- ..... 192.... Registrar.

Robert P. Harrison

Burial Permit Issued.

EP 2 31924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 21/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1924, to Sept 20 1924

that I last saw him alive on Sept 20 1924

and that death occurred, on the date stated above, at 10, 30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 2 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis, Alcoholic

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. M. Sadler M. D.

9/23. 1924 (Address) 330 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	9. 25. 24. 19....
20-UNDERTAKER.	ADDRESS
J. Fen McCully	130 S. Front

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90479

CERTIFICATE OF DEATH.

24 188-083 D 90479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General HOSPITAL ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie O. Carneal.

(a) RESIDENCE NO. 159 E. Randall St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Muscar Carneal.

6 DATE OF BIRTH (month, day, and year) April 18, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Frederick A. Tull.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Isabelle F. King.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Charles R. Carneal. (son)
(Address) 3808 Maine Ave.

15 Filed . 192 Registrar

Burial Permit Clerk.

SEP 23 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 20, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Struck and knocked down by an automobile while crossing the street.
Accidental Death.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Karl Reinhardt, M. D.
(Coroner.)

Sep. 28, 192 4 (Address) 101 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Randall & Byrd Sts. Sept. 20, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 9/24 192 4

20 UNDERTAKER J. Few McCarthy

ADDRESS 130 E. [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90480

CERTIFICATE OF DEATH.

129 D 90480

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3982 Elm Ave ST., 13 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J Chaney

(a) RESIDENCE No. 3982 Elm Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced [redacted] of (or) WIFE of Jesse Chaney

6 DATE OF BIRTH (month, day, and year) April 11, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72.	5.	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm A Burrows

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Wills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Joseph Sipley
(Address) 3982 Elm Ave

15 SEP 23 1924, 19 .....
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 19 24, to Sept 23, 19 24.
that I last saw him alive on Sept 22, 19 24.
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Uremia

Hypertension (duration) yrs. mos 4 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 6 yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas F Kelley, M. D.

9/23 1924 (Address) 3705 Jackson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cem Hampden DATE OF BURIAL Sep 26 1924

20 UNDERTAKER CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90481 D 90481

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S. Balto General Hospital St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME CALVIN ACREE

(Residence in Baltimore: No. Rear 13 Cedar St. Curtis Bay St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 23, 1923
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 6 mos. 0 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Alvin Acree

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Fanny Clancy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Acree

(Address) Masonville Md

15-

Sep 23 1924 Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1924, to Sept 22 1924, that I saw h[illegible] alive on Sept 21 1924, and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

..... (Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) Furuncle Head Bruised

..... (Duration).....yrs. 1 mos.....ds.

(Signed) Chas L. Stamp M. D.

Sept 23, 1924 (Address) 26 S. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 4 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? None

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, Sept 27, 1924

20-UNDERTAKER George L. Stamp ADDRESS 211 Fulton Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 W. West St. ST., 23 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Martin. (C)

(a) RESIDENCE NO. 46 W. West St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. ---mos.----ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Married.

5a If married, widowed or divorced XXXXXXXXXXXXXXXX (or) WIFE of LeRoy Martin. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Thomas Neal. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Jennie Nickens. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lannie Griffin. (C) aunt.
(Address) 46 W. West st.

15 Filed SEP 24 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Bernhardt (Coroner), M. D.

Sept. 23, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Sept 24 1924

20 UNDERTAKER J. L. Brown & Son — ADDRESS 1400 Monroe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-007 D 90483

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Libon

(a) RESIDENCE No. 215 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Dec 17/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Irving Libon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hilda Shapiro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto St

15 Filed SEP 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held nn inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suppurative Spinal-Meni gitis

(Labratory-Spinal Puncture)

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Pattison, M. D.
(Coroner.)

9/24/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rozedale — DATE OF BURIAL 9/24 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1492 Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BINDING MARGIN

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90484

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 W. Fayette ST., 18 WARD)

2-FULL NAME Henry Scheid

(a) RESIDENCE NO. 1024 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary T. Scheid

6 DATE OF BIRTH (month, day, and year): Oct 1-1865

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer): Assisting Machinist

(c) Name of employer: Crown Cork & Seal Co (Inc)

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: John Scheid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Scheid (Son)
(Address): 1527 N. Milton Ave

15 Filed SEP 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Sept 22, 1924, that I last saw him alive on Sept 21, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. mos 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal Examination

(Signed) Henry C. O'Leta, M. D.

(Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 9/27 1924

20 UNDERTAKER: John Welsh — ADDRESS: 200 Block

Cor.—1-12-23—M&T—100 Bks.

D 90485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 90485

REGISTERED NO.

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Bety

(a) RESIDENCE NO 1012 S. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob F. Bety

6 DATE OF BIRTH (month, day, and year) Aug. 14 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) Balto City.
(State or country)

PARENTS

10 NAME OF FATHER John Scherman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mr Kenwood

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Frank D. Bety
(Address) 1012 S Kenwood Ave

15 Filed SEP 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) I find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries over whole body
Supposed her Clothing Caught
fire from Hot Ashes on Floor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden

(duration) yrs. mos. ds.

(Signed) James M Fenlon, M. D. (Coroner.)

Sept 23 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews — DATE OF BURIAL Sept 25 1924

20 UNDERTAKER Finkler & Finkler — ADDRESS 1739 Eager

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90486

CERTIFICATE OF DEATH.

31 D 90486

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 S Carrollton Ave ST., 18 WARD)

2-FULL NAME May S Sommers

(a) RESIDENCE NO. 34 S Carrollton ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F Sommers

6 DATE OF BIRTH (month, day, and year): June 1, 1892

7 AGE — Years: 32 — Months: 3 — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm B Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John F Sommers
(Address) 34 S Carrollton Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/21/1924

17

I HEREBY CERTIFY, That I attended deceased from 2/14, 1923, to 9/21, 1924,

that I last saw h[illegible] alive on 9/21, 24, 19

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pul Phthisis

(duration) unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

9/24, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 9/23 1924

20 UNDERTAKER: Jno A Farley — ADDRESS: Fulton & Fayette

SEP 23 1924

ROBERT P. KRAUTER
Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90487

CERTIFICATE OF DEATH.

129

D 90487

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... (Brother Basil) Jos. Hutchins

(a) Residence No. Mt. St. Josephs College St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 25-1846

7-AGE. 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country) Kentucky

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (city or town)... (State or Country) " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country) " " "

14-

(Informant)...

(Address) Hospital Records.

15- Filed SEP 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 16th 1924 to Sept 23rd 1924, that I last saw him alive on Sept 23rd 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis +
interstitial nephritis with generalized arteriosclerosis.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis?

(Signed) J. S. Rhoads M. D

, 19 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Cathedral Cem.	Sept 25, 1924
20-UNDERTAKER,	ADDRESS
F. A. Kramer & Son	508 Aisquith St

Spec.—1-10-21—M&T—1500 Blks.

D 90488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 112 E. Hamilton ave ST., Hamilton WARD)

2-FULL NAME Annabelle Shanklin

(a) RESIDENCE No 112 E. Hamilton Ave ST., Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. R. Shanklin

6 DATE OF BIRTH (month, day, and year) March 8th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry H. Gontrum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sarah F. Coridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant John S. R. Shanklin

(Address) 112 E. Hamilton Ave

SEP 24 1924

ROBERT N. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1924

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to Sept 23, 1924

that I last saw her alive on Sept 23, 1924

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Medullary Carcinoma of Liver

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Medullary Carcinoma of Left Breast

(duration) 7 yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Radical Removal of Left Breast (Medullary Carcinoma) Date of July 20/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

Sept 24 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sept. 25 24
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stec—12-23-21—E.B.R.S.—400 Bks.

D 90489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90489

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 53 E. Hamilton ave. St., Hamilton Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ehrhardt

(a) Residence No. 53 E. Hamilton ave. St., Hamilton Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Ehrhardt

6-DATE OF BIRTH (month, day and year) March 9th 1857

7-AGE. 67 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Co.

(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) John G. Ehrhardt

(Address) 53 E. Hamilton Ave. Hamilton

15- SEP 24 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-22-24

17- I HEREBY CERTIFY, That I attended deceased from 9-18 19.24 to 9-22 19.24

that I last saw h.. alive on 9-22 19.24

and that death occurred, on the date stated above, at 7.10 a.m.

The CAUSE OF DEATH* was as follows:

Uremia Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Tenderness

(Signed) F. Zeff Wingard M. D.

9-22 19.24 (Address) 80 S. Potomac St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Parkwood Cmetery	Sept. 26, 1924
20-UNDERTAKER, Fredk Lansdowne Sons	ADDRESS Fidleston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90490

CERTIFICATE OF DEATH.

37

D 90490

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 4512 Penhurst Av ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Middleton

(a) RESIDENCE No. 4512 Penhurst Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. - mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager of Telegraph Station

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Postal Telegraph

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William F Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co Md

12 MAIDEN NAME OF MOTHER Stella Mary Foist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs William F Middleton

(Address) 4505 Fernhill Ave

15 SEP 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1924, to Sept 23, 1924, that I last saw him alive on Sept 23, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Meningitis

Blood Report pending for (duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Typhoid Infection

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Out of city.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Gray, M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Sept 26, 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

Georgia Thelma Rhoades ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90491

CERTIFICATE OF DEATH.

X 155 D 90491

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Georgia Thelma Rhoades

(a) RESIDENCE NO. Rock, Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer .....

9 BIRTHPLACE (city or town) Rock.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lida Rhoades

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Minnie Porter

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) North Carolina

14 Informant Lida Rhoades
(Address) .....

15 Filed Sept 25 1924 Robert P. Harrison, Registrar

P 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1924, to Sept 24, 1924,

that I last saw h.r. alive on Sept 24, 1924,

and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Coccio-Myelitis of Left Ventricle and right Thorax

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Rock, Maryland

Did an operation precede death? Yes Date of Sept. 23

Was there an autopsy? no

What test confirmed diagnosis? operation.

(Signed) M Edwards M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Md	Sept 25 1924

20 UNDERTAKER Dennis Foster Baltimore Md
ADDRESS J. F. Foster

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90492

CERTIFICATE OF DEATH.

90 D 90492

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Conway ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Heinz

(Residence in Baltimore: No. 528 Conway St. St.; 82 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept – ....., 18..... (Month) (Day) (Year)

7-AGE, 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, David Heinz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorothea

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Heinz

(Address) 528 Conway St.

15-

Filed ....., 191.....

SEP 24 1924

Robert F. Carrico, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1924, to Sept 23 1924, that I saw h.. alive on Sept 23 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Hamilton Bond M. D.

Sept 24, 1924 (Address) 502 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Dallsfenday — DATE OF BURIAL. Sept 25 1924

20-UNDERTAKER Robt Johnson Bro — ADDRESS 1424 Pa Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90493 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90493

100 001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 527 N Bouldin St., 2d Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Frank J. Carpenter

(a) Residence No. 527 N. Bouldin St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND ~~of (or) WIFE~~ of Agnes A Carpenter

6-DATE OF BIRTH (month, day and year) Dec 25 1867

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telegrapher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Brooklyn N.Y.

PARENTS.
10-NAME OF FATHER, John Carpenter
11-BIRTHPLACE OF FATHER (city or town) (State or Country), England
12-MAIDEN NAME OF MOTHER, Fannie Redford
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14-(Informant) Agnes A Carpenter
(Address) 527 N. Bouldin St

15-[illegible] Registrar.

SEP 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 22 1924

I HEREBY CERTIFY, That I attended deceased from Sept 19 1924 to Sept 22 1924

That I last saw h[illegible] alive on Sept 22 1924

and that death occurred, on the date stated above, at 11 AM

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(Duration) 3 days

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1400 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Sept 26, 1924

20-UNDERTAKER.	ADDRESS
Robt P Jones & Son	1422 W Pratt

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 24 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2026 Brookfield Avenue St., 13 Ward)

Registered No. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Robert Goss.....

(a) Residence No..... 2026 Brookfield Avenue St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A. Goss

6-DATE OF BIRTH (month, day and year) Nov. 7, 1838

7-AGE, 85 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) (retired)

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore County
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Goss

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Nancy Towers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Miss Aimee D. Goss

(Address) 2026 Brookfield Avenue

15- Filed SEP 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Sept 23, 1924

that I last saw him alive on Sept 23, 1924

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Fibrosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Standish McAleer, M. D.

9-24, 1924 (Address) 1609 Linden Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Sept 26, 1924
20-UNDERTAKER, Joseph B Cook	ADDRESS 1023 W Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Whitmore Ave St., 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Spies

(a) RESIDENCE No. 1812 Whitmore Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? 60 yrs. 2 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia E. Spies

6 DATE OF BIRTH (month, day, and year) March 18, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Jos Pugh (Address) 1812 Whitmore Ave

15 Robert P. Harrison, Registrar

SEP 24 1924

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-5 , 1924, to 9-24 , 1924, that I last saw h alive on 7-23 , 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows: Carcinoma of hand

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Metastases to liver and intestines (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) H. Pinto, M. D.

9-24 1924 (Address) 2202 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 26 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS W. North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90496 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90496

CERTIFICATE OF DEATH.

75.00

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., V Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... August Ellerbrock

(a) Residence No. 119 S. Ann St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Ellerbrock

6-DATE OF BIRTH (month, day and year) Aug 18-1834

7-AGE. 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not Know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) " " "

14- (Informant) Joseph F. Ellerbrock, (Address) Delray Av. Catonsville

15- Filed SEP 24 1924 192.. Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/22/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1924 to Sept 22, 1924 that I last saw him alive on Sept 22 nd, 1924 and that death occurred, on the date stated above, at 8.05 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - hypostatic

Coronary occlusion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis

with L.T. Hemiplegia (Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? U Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes.

(Signed) V. D. Adams, M. D

9/24, 1924 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem	Sept 25, 1924
20-UNDERTAKER. Lilly & Zeiler	ADDRESS 403 S. Wolfe St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90497

CERTIFICATE OF DEATH.

90 D 90497

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2504 E. Fairmount ave. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliana Dittmann

(a) Residence No. 2504 E. Fairmount ave. 6 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Andrew Dittmann

6-DATE OF BIRTH (month, day and year) Nov. 8th 1842

7-AGE. 81 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Adam Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katharine Reitz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Andrew [redacted]

(Address) 2504 E. Fairmount ave.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

SEP 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from Sep. 16, 1924 to Sep. 21, 1924

that I last saw h.. alive on Sep. 21, 1924.

and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Gall - stones.

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis (Chronic)

(Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) E. L. Crossland, M. D

9.22, 1924 (Address) Ten Hills

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem.	Sept. 25th 1924
20-UNDERTAKER, Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90498

D 90498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Curfman

(a) RESIDENCE NO. 1 Echodale Ave (Gardenville) ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Curfman

6 DATE OF BIRTH (month, day, and year) Feb 2/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	7	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Freight Handler
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) Detour,
(State or country) Frederick Co., Md

PARENTS

10 NAME OF FATHER John F. Curfman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriett Forney

13 BIRTHPLACE OF MOTHER (city or town) Fred. Co.
(State or country)

14 Informant Catherine Albert Curfman
(Address) 1 Echodale Ave

15 Filed SEP 24 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock-hemorrhage--Run over by street car on Belair Road
crushed skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Culley, M. D.
(Coroner.)

9/24/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Sept 25 1924

20 UNDERTAKER George Schuling & Sons — ADDRESS 1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90499

CERTIFICATE OF DEATH.

188-D 90499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Albert Curfman

(a) RESIDENCE No. 1 Echodale Ave (Gardenville) ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 25/1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. A. Curfman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Albert

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Catherine Albert Curfman
(Address) 1 Echodale Ave

15 Filed SEP 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- hemorrhage- runover by street car on Belair Road

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Pallen, M. D.
(Coroner)

9/24/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Sept 25 1924

20 UNDERTAKER George Schulling & Sons — ADDRESS 1126 E Monument

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90500

CERTIFICATE OF DEATH.

101-08 B 90500

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N. Eutaw ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethie Elizabeth Thompson

(a) RESIDENCE NO. 622 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. R. Thompson

6 DATE OF BIRTH (month, day, and year) Feb 8 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER William Weller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Doubtful

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant W. R. Thompson

(Address) 622 N. Eutaw St.

15 SEP 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1924, to Sept. 24, 1924, that I last saw her alive on Sept 24, 1924, and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchman, M. D.

, 19 (Address) 650 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hobbs Md DATE OF BURIAL Sept 26 1924

20 UNDERTAKER Chas. E. Francis ADDRESS for Madison

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90501

CERTIFICATE OF DEATH.

90

D 90501

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 Ellamont ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 100 Ellamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Smith

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 54; Months; Days; If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md.

PARENTS

10 NAME OF FATHER: George Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co.

12 MAIDEN NAME OF MOTHER: Matilda Greene

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co.

14 Informant: Martha Greene

(Address): 100 Ellamont Ave

15 SEP 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-22-1924

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1924, to 9/22, 1924, that I last saw h[illegible]live on 9/22, 1924, and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) yrs. mos. 32 ds.

CONTRIBUTORY (Secondary) Valvular heart disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 1008 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 9/24/24

20 UNDERTAKER: Daniel Caplan

ADDRESS 916 Cathedral

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

16

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90502

CERTIFICATE OF DEATH.

47 ✓

Registered No. D 90502

1-PLACE OF DEATH 115 Faisquith street

City of BALTIMORE: (No. Hebrew aged Home St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mesha Pachmus

(a) Residence No. 2117 E. Pratt street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Pachmus

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 85 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Hyman Pachmus

(Address) 2117 E. Pratt St.

15- SEP 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 th, 1924, to Sept 25 th, 1924, that I last saw h[illegible] alive on Sept 24, 1924, and that death occurred, on the date stated above, at 5 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Levinson M. D.

7-25, 1924 (Address) 30 S. 15th way

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Hebrew Reomel	9/25 1924
20-UNDERTAKER.	ADDRESS
Joseph Lewis	1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 ✓

REGISTERED NO. D 90503

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp 1st. 16 WARD)

2-FULL NAME Baby Kayser

(a) RESIDENCE NO. 1702 N. Fanwake St WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 16th 24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Aguilar Kayser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant [redacted] (Address) 1702 W Fanwake St

Filed SEP 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24th 1924

17 I HEREBY CERTIFY, That I attended deceased from 9—16, 1924, to 9—24, 1924.

that I last saw h[redacted] alive on Sept 24, 1924,

and that death occurred, on the date stated above, at 11:30a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Removal of tumor from head. (duration) yrs. mos. ds. Four

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept. 24th

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam.

(Signed) AC Manning, M. D.

(Address) Sept 24, 1924 Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Hebrew Friendship

DATE OF BURIAL 9/27 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1431 E Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90504

CERTIFICATE OF DEATH.

89 ✓ D 90504

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S Gilmor St ST., 19 WARD)

2-FULL NAME Charles A Stiner

(a) RESIDENCE NO. 235 S Gilmor St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Stiner

6 DATE OF BIRTH (month, day, and year) June 18, 1869

7 AGE Years	Months	Days	If LESS than 1 day..... hrs. or..... min.
55	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Detective

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm H Stiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Ann Stiner
(Address) 235 Baltimore

Filed SEP 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 19 24, to Sept 23, 19 24, that I last saw h living on Sept 23, 19....., and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Angenia Pectoris

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cookahan M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	27 19
20 UNDERTAKER	ADDRESS
Wm Fields	120 W Lombard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90505

CERTIFICATE OF DEATH.

D 90505

1-PLACE OF DEATH John Hopkins Hospital

CITY OF BALTIMORE, (No. ..... ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sibley

(a) RESIDENCE NO. 2177 Market St. WARD 4
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Sibley

6 DATE OF BIRTH (month, day, and year) Mar 30-1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Favor Sibley

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Malcom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records (Address) John Hopkins Hospital

Filed SEP 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Sept 21, 1924, that I last saw h— alive on Sept 21, 1924, and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Favor Owen, M. D.

Sept 26, 1924 (Address) Johns Hopkins Hospital Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cemetery — DATE OF BURIAL Sept 29 24

20 UNDERTAKER Samuel D. Hensley — ADDRESS 1128 E Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90506 — 74 ook 90506

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 939 Mulberry St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. W. Russell

(a) Residence No. 129 Mulberry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Bertie Russell

6-DATE OF BIRTH (month, day and year) Feb. 8 1872

7-AGE, 52 yrs. — mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Col Co Va

PARENTS.

10-NAME OF FATHER, Henry Russell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eliza Townsend

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Louise Newman (Address) 939 W. Mulberry St.

15- Filed SEP 25 1924 NOBLE N. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1924, to Sept. 22 1924, that I last saw h[illegible] alive on Feb. 22 1924, and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY — (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Bond E. Tilghman, M. D.

Sept. 24, 1924 (Address) 606 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL, 1924

20-UNDERTAKER, Samuel Hunsberger — ADDRESS 878 Bdle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 90507

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Druid St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Dora V. Wallace

(a) Residence No..... 507 Druid St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Fem	Col	Wid

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Benj. Wallace

6-DATE OF BIRTH (month, day and year) Aug 9 1868

7-AGE.	If LESS than 1 day.
56 yrs. — mos. — ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Georgia
(State or Country).

PARENTS.

10-NAME OF FATHER, Abed Johns

11-BIRTHPLACE OF FATHER (city or town)..... Georgia
(State or Country).

12-MAIDEN NAME OF MOTHER, Sarah Smith

13-BIRTHPLACE OF MOTHER (city or town)..... N.C.
(State or Country).

14- (Informant) Benjamin Wallace

(Address) 507 Druid St.

15- filed..... 19.. Registered.....

ROBERT R. KRAUTER
Deputy Registrar.

SEP 25 1924
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 22 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Sept 22, 1924, that I last saw h.. alive on Sept. 22, 1924, and that death occurred, on the date stated above, at 10:45 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frank E. Wilson, M. D.

Sept 25, 1924 (Address) 1426 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Sept 25 1924
p-UNDERTAKER.	ADDRESS
Samuel Wensley	W Balto

MARGIN RESERVED FOR BINDING.

—THIS IS A PERMANENT RECORD. Every item of information
INLY, WITH UNFADING INK—THIS
stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
e carefully supplied. AGE should be stated
ain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See
structions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 90508

CERTIFICATE OF DEATH.

11-002

Registered No. B 90508

1-PLACE OF DEATH

City of BALTIMORE: (No. 1460 Montpelier St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. Ford

(a) Residence No. 1460 Montpelier St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of X X X

6-DATE OF BIRTH (month, day and year) Sep 26 1910

7-AGE. 13 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) DNS

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Vincent P Ford

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Catherine E Sell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Vincent. P. Ford.

(Address) 1460 Montpelier

15- Filed SEP 25 1924 ROBERT A. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEP 24 1924

17- I HEREBY CERTIFY, That I attended deceased from SEPT 6 1924 to SEP 23 1924

that I last saw h.E.R. alive on SEP 23 1924

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) X yrs. X mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza and Bronchial Pneumonia

(Duration) X yrs. X mos. 7 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of X X

Was there an autopsy? No

What test confirmed diagnosis? Medical

(Signed) C. H. Stokes M. D.

SEP 24 1924 (Address) 928 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL. Sept 27 1924

20-UNDERTAKER. J W Cook

ADDRESS 702 Eastern Ave

SEP 25 1924 Baltimore City Health Dept.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90509

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1613 N. Fayette St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Nathan)

2-FULL NAME. Nathan P. Gorsuch

(a) Residence No. 1613 West Fayette St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Gorsuch

6-DATE OF BIRTH (month, day and year) April 14, 1875

7-AGE. 49 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Nathan Gorsuch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Hannah Gosnell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Fannie Myers

(Address) 316 N. Fulton Ave.

Filed SEP 25 1924 ROBERT R. KRAMES Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924, to Sept 23 1924, that I last saw h. alive on Sept 17 1924, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

+ Mitral Stenosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General debility, senile

Cardiac (Duration) 4 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? history & symptoms

(Signed) J. E. Bunger M. D.

Sept 24 1924 (Address) 600 York Road Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mayo Homeplace

DATE OF BURIAL. Sept. 25 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E North Ave

Burial Permit Clerk

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90510

D 90510

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 S. Castle ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Strand Weiss

(a) RESIDENCE NO. 21 S. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Weiss

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ellen Weiss
(Address) 21 S. Castle St.

15 Filed SEP 25 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 23 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to 9-23, 1924.

that I last saw him alive on 9-23, 1924

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Aleo Colitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Burgdorf M. D.

(Address) 800 N Bate St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 26 1924
20 UNDERTAKER	ADDRESS
Mrs. L. Miller & Son	2334 Jefferson St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90511

CERTIFICATE OF DEATH.

D 90511

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fayette & 12th ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sheckells Hamilton

(a) RESIDENCE No. 1020 N Milton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A Hamilton

6 DATE OF BIRTH (month, day, and year) Sept 24 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Horn Ice Cream Co

9 BIRTHPLACE (city or town) Salt Lake City
(State or country)

PARENTS

10 NAME OF FATHER Alexander J. Hamilton

11 BIRTHPLACE OF FATHER (city or town) Salt Lake
(State or country)

12 MAIDEN NAME OF MOTHER Susan Sheckells

13 BIRTHPLACE OF MOTHER (city or town) Salt Lake
(State or country)

14 Informant Frances A Hamilton
(Address) 1020 N Milton St

15 Filed SEP 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 4 yrs. ..... mos. ..... ds.

(Signed) James M Hamilton, M. D.
(Coroner.)

Sept 24 1924 (Address) 404 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Sept 27 1924

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

Spec.—1-10-21—M&T—1500 Bks.

Nettie Beshrk Bishop ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90512

CERTIFICATE OF DEATH.

90

D 90512

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Bolton ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Bishop

(a) RESIDENCE NO. 1118 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Graham Bishop

6 DATE OF BIRTH (month, day, and year) Feb 14-1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robt Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Celestine Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Henry Edwards

(Address): 1119 Bolton St

Filed SEP 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/24

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1924 to 9/23/24, that I last saw h alive on 9/23/24, and that death occurred, on the date stated above, at 10 6 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Lee Ellis M. D.

(Address) 72 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Saint Mary to Md Stanley Lucht	9-27 1924
20 UNDERTAKER	ADDRESS
Helen A. Holland	1631 Lanvale Hillen

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 90513

D 90513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH 503 Harman Ave

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Scott Ridgaway

(a) RESIDENCE. No. 503 Harman Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie H. RIDGAWAY

6 DATE OF BIRTH (month, day, and year) Sept 2d 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	✓	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk Dept Store

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer Bernheimer & Leader Store

9 BIRTHPLACE (city or town) (State or country) Talbott Co., Md.

PARENTS

10 NAME OF FATHER Samuel Scott RIDGAWAY

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co., Md.

12 MAIDEN NAME OF MOTHER Suzana Haddaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbott Co. Md.

11 Informant Ethel G. Ridgaway

(Address) 503 Harman Ave

15 ..... 19 .....

Robert P. Harrison, Registrar

SEP 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924, to Sept 24, 1924, that I last saw him alive on Sept 23, 1924, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H G Jones, M. D.

Sept 25, 1924 (Address) 720 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 27 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Thrasher	1018 Edmondson Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90514

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 12 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Groom

(a) Residence No. 127 W. 20th street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1898

7-AGE: 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: Richard Groom

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Marie Clark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed: Robert P. Harrison, Registrar.

SEP 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 29 1924 to Sept. 23 1924

that I last saw h. alive on Sept. 23 1924

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Laryngeal tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Richard Schad, M. D.

9-23-. 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER.	ADDRESS

STATE BOARD OF MARYLAND Commissioner Health. SEP 25 1924

MARGIN RESERVED FOR BINDING.

18—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90515

CERTIFICATE OF DEATH.

D 90515

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Williams

(a) Residence No. Pimlico Race Track St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1881

7-AGE.	If LESS than 1 day
43 yrs. ..... mos. ..... ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Montana
(State or Country).

PARENTS.

10-NAME OF FATHER, Geo Williams

11-BIRTHPLACE OF FATHER (city or town) Montana
(State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Montana
(State or Country).

14- (Informant) Municipal Hospital Record

(Address).....

15- Filed ..... 192 Robert P. Harrison, Registrar.

SEP 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-23-24

17- I HEREBY CERTIFY, That I attended deceased from 8-28 ....., 1924, to 9-23 ....., 1924

that I last saw him alive on 9-23 ....., 1924

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Insufficiency; Myocardial Insufficiency

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Claude D. Howe, M. D.

9-23-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19....
20-UNDERTAKER. [illegible]	ADDRESS

Per, Wm. E. Woods SEP 25 1924

MARGIN RESERVED FOR BINDING.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90516

CERTIFICATE OF DEATH.

D 90516

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Presbyterian Eye Ear & Throat Hosp. St.; ..... Ward)

2-FULL NAME Catherine A. Mindeleun

(Residence in Baltimore: No. 230 S. Washington St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 12 (Day), 1912 (Year)

7-AGE, 12 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Attended
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Conrad Mindeleun

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Veronica Wesh

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Veronica Mindeleun

(Address) 230 S Washington St

15- Robert P. Harrison, ..., 191.....

Burial Permit Clerk Registrar.

SEP 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1924, to Sept 24 1924, that I saw her alive on Sept 23 1924, and that death occurred, on the date stated above, at 1.57 P.M.

The CAUSE OF DEATH* was as follows:

Orbital Cellulitis

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Eug. Emil Gilbert M. D.

Sept 24, 1924 (Address) 2739 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Sept. 27, 1924

20-UNDERTAKER Kelly & Gale ADDRESS 403 S. Mott St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.--1-12-23--M&T--100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90517

CERTIFICATE OF DEATH.

90 D 90517

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Filtration Plant (Montebello) ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin L. Krotee

(a) RESIDENCE NO. 2616 Keyser ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Krotee

6 DATE OF BIRTH (month, day, and year) Dec 28/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City
(c) Name of employer Water Dept.

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Harry J. Krotee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mary J. Krotee (Wife.) 2616 KeyserSt

15 SEP 25 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (Probably Valvular)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Weller, M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Sept 27th 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90518

CERTIFICATE OF DEATH.

94

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give NAME instead of street number and fill out No.)

2-FULL NAME Henry Antkowiak

(a) RESIDENCE NO. 205 S. Madeira St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Sept. 14/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Antkowiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ida Gisa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant James Antkowiak
(Address) 205 S. Madeira St

15 SEP 25 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Status Lymphaticus

(Died in convulsions), no autopsy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cullen (Coroner), M. D.

9/25/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sep. 27 192 4

20 UNDERTAKER John Weber ADDRESS 1803 Bank St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

VD 90519

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D~~ 90519

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME Mary C. Holder

(a) RESIDENCE No. 1822 Dover ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Holder.

6 DATE OF BIRTH (month, day, and year) March 20. 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bag Sewer 169

(b) General nature of industry, business, or establishment in which employed (or employer) Wilkens Hat Factory

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER ? Koehler

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs Laurence Manfield
(Address) 429 S Paca St

15 SEP 25 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24- 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-10- , 1924, to 9-24- , 1924,

that I last saw h.. alive on 9-24- , 1924,

and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Disease of Tongue of Back

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. J. Parr, M. D.

9/24, 1924 (Address) Franklin Sq. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 27 1924
20 UNDERTAKER	ADDRESS
Henry H Nitzke	1531 N Londen St

MARGIN RESERVED FOR ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90520

D 90520

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 806 N. Lombard St.

CITY OF BALTIMORE: (No. 806 N. Lombard St. ST. 18 WARD)

2-FULL NAME Margaret Rakowsky.

(a) RESIDENCE No. 806 N. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Late Casmer Rakowsky

6 DATE OF BIRTH (month, day, and year) March 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Lucas Perzynski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Antony Rakowsky

(Address) 1064 Fayette Baltimore

15 ..... 19 ..... Robert T. Harrison, Clerk Registrar

SEP 25 1924

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Sept 23, 1924, that I last saw h[illegible] alive on Sept 23, 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) ... yrs. Insane mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Louis A. Elliot, M. D.

9/25, 1924 (Address) 541 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Hamo's Cemetery	Sept 26 1924
20 UNDERTAKER	ADDRESS
Harry K. Metzler	1531 N. Fenwick St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90521

CERTIFICATE OF DEATH

101 001 D 90521

1-PLACE OF DEATH Vet Baltimore General Hospital

CITY OF BALTIMORE: (No. Cor Payson & Lakeland St.) 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louise M Roeth

(a) RESIDENCE No. 2006 N Payson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (~~HUSBAND~~ or) WIFE of A. C. L. Roeth

6 DATE OF BIRTH (month, day, and year) May 6 1872

7 AGE: Years 52 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Gerhart Landsiedel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs C. McC Lemley (Sister)

(Address) Morgantown W. Va.

15 Robert P. Harrison Registrar

Burial Permit Clerk

SEP 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 20th, 19 24, to Sept 25, 19 24, that I last saw h[e] alive on Sept 25, 19 24, and that death occurred, on the date stated above, at 4:10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2006 N Payson

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clement R. Monroe, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Sept 27 1924

20 UNDERTAKER: Harry H Metzke — ADDRESS: 1531 N Gilmor St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90522

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 90522

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital (ST.) No (WARD)

2-FULL NAME Mildred Szymczewski

(a) RESIDENCE NO. 618 S. Bouldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 14, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none yrs
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Arthur Szymczewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Stella Swebow

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Arthur Szymczewski
(Address) 618 S Bouldin St

15 SEP 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ist Burns over body
Shefield burned & that
water over burned - her
home accident (duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) James M Fenton, M. D.
(Coroner.)

Sept 27 1924 (Address) 700 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., 1 ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 618 S Bouldin St

Former or usual residence 618 S Bouldin St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Sept 26 1924

20 UNDERTAKER F W Ozazewski — ADDRESS 1930 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90523

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 Croswell St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Madison E. McElroy.

(a) Residence No. 1700 Croswell St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widower

5a-If ~~married~~, ~~widowed~~, or ~~divorced~~, HUSBAND of (or) ~~WIFE of~~ Molly McElroy.

6-DATE OF BIRTH (month, day and year) Apr 26-1847

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER James McElroy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Louis Woldschmidt

(Address) 1700 Croswell

15- SEP 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924 to Sept 24, 1924

that I last saw him alive on Sept 24, 1924

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9-24, 1924 (Address) 1700 Hanford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery — DATE OF BURIAL. Sept 26, 1924

20-UNDERTAKER Robt J Turner Sr — ADDRESS 1942 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90524

CERTIFICATE OF DEATH.

D 90524

1-PLACE OF DEATH

City of BALTIMORE: (No. 244 S. Highland Ave. St., 16 Ward)

Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Kirchheimer

(a) Residence No. 244 S. Highland Av. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late Louis Kirchheimer

6-DATE OF BIRTH (month, day and year) Aug 19/55

7-AGE. 69 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, John Voigt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louis Kirchheimer (Address) 244 S. Highland Ave

15- SEP 26 1924 ROBERT P. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25/24

17- I HEREBY CERTIFY, That I attended deceased from 1-8-24, 19, to 9-25-24, 19, that I last saw h[illegible] alive on 9-24-24, 19, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Frederick Dittman M. D.

9-25-24 (Address) 913 E. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn — DATE OF BURIAL, Sept. 28, 1924

20-UNDERTAKER, Philip Herwig — ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90525

CERTIFICATE OF DEATH.

109-002 90525

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 625 N. Rose St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret L. Mace

(a) Residence No. 625 N. Rose St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 13/07

7-AGE. 16 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Alonza S. Mace

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER, Lillian E. Alfes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Alonza S. Mace

(Address) 625 N. Rose

15- Filed SEP 26 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 1924 to Sept 24 1924

that I last saw her alive on Sept 24 1924

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

(Primal) Endocarditis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (hypostatic)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis A. M. Krause M. D.

19 (Address) 2500 E. Madison St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. DATE OF BURIAL. 10/27 1924

20-UNDERTAKER. Philip Herwig ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

90526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86-601 D 90526

Registered No.....

1-PLACE OF DEATH St. Adolphis Hosp - 10

City of BALTIMORE (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Scheff

(a) Residence No. 1208 East Chase St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of [illegible] Catherine Scheff

6-DATE OF BIRTH (month, day and year) Feb 25 1870

7-AGE. 44 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Assistant Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer. Baker Constr. Co.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Peter Scheff

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Rachel Lohman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14-

(Informant) Mrs Catherine Scheff

(Address) 1208 E Chase St

15-

Filed SEP 26 1924 ROBERT R. KRAUSE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 24 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 19 24 to Sept 24 19 24

that I last saw him alive on Sept 24 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Brain abscess

Pneumonitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Otitis Media, Mastoiditis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Path

(Signed) Geo B Snader M. D.

. 19 (Address) St Josephs Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Sept 27 19 24

20-UNDERTAKER. Elmer W Conklin — ADDRESS 924 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90527

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 355 Fort Hill St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Vernon Nelson Spiegel

(a) Residence No. 355 Fort Hill Ave St., 70 Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-15-23

7-AGE, ...yrs. 9 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Spiegel

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Jeanne Eisenbacher

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) L. Spiegel

(Address) 355 Fort Hill Ave

15- SEP 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-24-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 19 24 to Sept 24 19 24

that I last saw h[illegible] alive on Sept 23 19 24

and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

As Stated Collapse

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M. A. Knell M. D

9/24, 1924 (Address) Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Balto. Jos. Cem. | DATE OF BURIAL, Sept. 26 1924

20-UNDERTAKER, George L. Schwartz | ADDRESS Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+19 D 90528

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Parker. (C)

(a) RESIDENCE NO. Savington, A. A. Co. Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos.---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced, HUSBAND of (WIFE of) Arthur Ann Parker. (C)

6 DATE OF BIRTH (month, day, and year) November 17, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Parker. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ida Parker. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Arthur Ann Parker. (C) wife.
(Address) Savington, A. A. Co. Md.

15 SEP 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Septicaemia.
due to shot gun wounds of lower third of left thigh. Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Einhaus, M. D. (Coroner.)

Sept. 25, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Shot at Edenton, Md. Sept. 20, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waterbury & Co. Md. DATE OF BURIAL Sept 26 1924

20 UNDERTAKER B. L. Hopkins ADDRESS Annapolis Md.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90529

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 313 Forrest St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Taylor

(a) Residence No. 313 Forrest St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. C.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 1873

6-DATE OF BIRTH (month, day and year) 1873

7-AGE. 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Contractor

(b) General nature of industry, business, or establishment in which employed (or employer). do

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

11- (Informant). Ella Taylor

(Address) 313 Forrest St.

SEP 26 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19- 1924, to Sept. 24 1924

that I last saw him alive on Sept 23- 1924

and that death occurred, on the date stated above, at 11.30 A. M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma Dropsy Chronic

Nephritis (Duration) yrs. 5 mos. 18 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr G W Kennard M. D

9-25. 1924 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery — DATE OF BURIAL. Sept 27 1924

20-UNDERTAKER. Wm R. C. Elliott — ADDRESS 1715 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90530

CERTIFICATE OF DEATH.

113 ✓ D 90530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 249 S. Caroline ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward John Smith

(a) RESIDENCE No. 249 S Caroline ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John E Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore and

12 MAIDEN NAME OF MOTHER Alice Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster

14 Informant Mrs Alice Smith

(Address) 249 S Caroline St

15 Filed SEP 26 1924 ROBERT E. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 . 1924 . to Sept 25 . 1924 .

that I last saw h alive on Sept 25 . 1924 .

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) diarrhea and convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Character of stools etc

(Signed) M N Cutterman, M. D.

Sept 26 1924 (Address) 2214 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Sept 26 1924

20 UNDERTAKER John McWeber — ADDRESS 1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90531

CERTIFICATE OF DEATH.

5

D 90531

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 McPhail ST., 70 WARD)

2-FULL NAME Matilda Landel

(a) RESIDENCE No. 148 McPhail ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Landel

6 DATE OF BIRTH (month, day, and year) Aug 30 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ohd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Jaekel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Kettberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Richter

(Address) 342 S Wallwood St

15 Date SEP 26 1924 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to Sept 24, 1924

that I last saw h alive on Sept-23, 1924

and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ... yrs. 6 mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) James R Engelhart M. D.

9/24, 1924 (Address) 1729 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Friday 26 1924
20 UNDERTAKER Wm Albert Fuller	ADDRESS 806 Gilford Ave

Spec—12-23-21—E.B.R.S.—400 Bks. 2231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90532

CERTIFICATE OF DEATH.

31

D 90532

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1111 E. Balto st St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harman Lindenberger

(a) Residence No. 1111 E. Balto St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE,	If LESS than 1 day,
58 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mail

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant) S. Lindenberger

(Address) 1111 E. Balto st

15- SEP 26 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept, 1924, to Sept 26, 1924

that I last saw him alive on Sept 25, 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. Bacilli in sputum

(Signed) Jacob Slyter, M. D.

Sept 26, 1924 (Address) 223 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 1924
Hebrew Rosedale	Sept 26
20-UNDERTAKER.	ADDRESS 1127 E Balto st
A. Lennsar & Bro	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

KohLhEPP

90533

HEALTH DEPARTMENT—CITY OF BALTIMORE

90533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2213 Mt Holly St Ward 45)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L Kohlhepp

(a) Residence No. 2213 Mt Holly St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of WIFE Minnie Kohlhepp

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Book Keeper

(b) General nature of Industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Bulls City

PARENTS

10-NAME OF FATHER John Kohlhepp

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Elmira Will

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-Filed SEP 26 1924 (Informant) Harry Kohlhepp

(Address) 2213 Mt Holly St

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25/24

17- I HEREBY CERTIFY, That I attended deceased from July 29th 1924 to Sept 25 1924

that I last saw him alive on Sept 24 1924

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. ours ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julian F Stellmann M. D

19 (Address) 6 E. Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 27 1924
20-UNDERTAKER	ADDRESS
Martin Fuhrer & Son	1214 W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Jarousak)

D 90534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90534

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 503 S Chester St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Jarousak .....

(a) Residence No. 503 S Chester St., 1st Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~, HUSBAND of ~~[illegible] WIFE~~ of Late Barbara Jarousak

6-DATE OF BIRTH (month, day and year) Aug 24th 1848

7-AGE, 76 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... O'H O
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Little City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs J. J. Somansfield
(Address) 505 S Chester St

15- Robert P. Harrison, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). ~~Sept~~ 9/25/24

17- I HEREBY CERTIFY, That I attended deceased from July 16th 1924 to Sept 23 1924

that I last saw h.m alive on Sept 23, 1924

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis sclerosis inter-
stitial nephritis

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Gallstones & Heart failure

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wm. H. Armitage, M. D.

9/26, 1924 (Address) 162 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 27, 1924

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

P 2 61924

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90535

CERTIFICATE OF DEATH.

3/ D 90535

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3436 Cedar Ave ST., 13 WARD)

2-FULL NAME Charles Ing Murnaw

(a) RESIDENCE NO. 3436 Cedar Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Annie G. Murnaw

6 DATE OF BIRTH (month, day, and year) Sept 16-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor, 040

(b) General nature of industry, business, or establishment in which employed (or employer) Coron Cork & Seal

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm H. Murnaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Annie G. Murnaw
(Address) 3436 Cedar Ave

15 Filed SEP 26 1924, 19 Robert P. Merrick, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Sept 26, 1924,

that I last saw h~~i~~m alive on Sept 26, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary
tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum examination

(Signed) W. W. Smith, M. D.

Sept 26 1924 (Address) 842 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 27 1924

20 UNDERTAKER	ADDRESS
A S Marshall	3539 Falls Road

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90536

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4132 Falls Road ST., 13 WARD)

2-FULL NAME Edward N. Powell

(a) RESIDENCE No. 4132 Falls Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida M. Powell

6 DATE OF BIRTH (month, day, and year) July 18 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) W Md. R Ry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER Lewis M Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Amelia Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Mrs Ida M Powell (Address) 4132 Falls Road

15 SEP 26 1924 . 19 Robert P. Harrison, Registrar

Assistant Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. , 1923 , to Sept 23 , 1924 ,

that I last saw him alive on Sept 23 , 1924 ,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Anemia nephritis & hypertension.

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W W Smith M. D.

Sept. 1924 (Address) 842 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 27 1924

20 UNDERTAKER A. D. Marshall ADDRESS 2539 Falls Road

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90537

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 90537

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2914 Ivon Terrace St. 7 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Bernard Joseph McGinnity

(a) Residence No. 2914 Ivon Terrace St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5 ~~Single~~, Married, ~~Widowed or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McGinnity

6-DATE OF BIRTH (month, day and year) Aug. 7 - 1864

7-AGE, 59 yrs. ..... mos. ..... ds. LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore, Md

(State or Country),

PARENTS.

10-NAME OF FATHER, Bernard McGinnity

11-BIRTHPLACE OF FATHER (city or town). Baltimore

(State or Country),

12-MAIDEN NAME OF MOTHER, Mary O'Keefe

13-BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or Country).

14- (Informant). Mary McGinnity

(Address)..... 2914 Ivon Terrace

15- [illegible] 192 .....

Registrar.

SEP 26 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 24 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to Sept 24 1924.

that I last saw him alive on Sept 24 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia +

Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clarence Jones, M. D

9/25/24 (Address) 4706 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	Sept. 27 1924
20-UNDERTAKER.	**ADDRESS**
Geo. J. Ruth	1735 Harford Ave.

NO. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90538

CERTIFICATE OF DEATH.

17 D 90538

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bayview Hospital ST., 1 WARD)

2-FULL NAME ~~Raymond Bennett~~ Raymond Bennett K

(a) RESIDENCE No 520 S Patterson Pk ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 13 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mah	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bennett

6 DATE OF BIRTH (month, day, and year) Dec 1 - 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mary Bennett
(Address) 520 S Patterson Pk

15 Filed SEP 26 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

30 Turns over whole body, He went into the Burning House was caught accident (duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Benton, M. D. (Coroner.)

Sept 25 1924 (Address) 700 E Chase

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Essex Balto Co.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 9/27/24 192

20 UNDERTAKER F W Ozazewski — ADDRESS 1730 Eastern

* B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital - WARD)

2-FULL NAME Baby Rosen

(a) RESIDENCE No. 1728 N. Bentalou St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. 161-04 90539

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 20 - 1924

7 AGE: Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Frank Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Augie Kepetrowsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Record

15 Filed SEP 26 1924, 19.... Robert F. Norris, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/26/24

17 I HEREBY CERTIFY, That I attended deceased from 9/20/24, 19..., to 9/26/24, 19..., that I last saw h... alive on 9/26/24, 19..., and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows: Prematurity

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

(Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holmes Herring Run — DATE OF BURIAL: 9-26-1924

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

oc—12-23-21—E.B.R.S.—400 Bks.

D 90540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 W. Hamburg St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Seipp

(a) Residence No. 711 W. Hamburg St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of Gottlieb Seipp

6-DATE OF BIRTH (month, day and year) Oct. 22 1867

7-AGE, 56 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Dauman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Rosina Schlosser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Gottlieb Seipp

(Address) 711 W. Hamburg St.

15- Filed, Sept 27 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 24-24

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to Sept 24 1924

that I last saw h[illegible] alive on Sept 24, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Carcinoma of Pylorus

Ascites

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

19 24 (Address) 711 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Sept 27, 1924

20-UNDERTAKER, [illegible] ADDRESS [illegible]

ec—12-23-21—E.B.R.S.—400 Bks.

D 90541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 90541

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1758 Homestead St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles W. Berndt

(a) Residence No. 1758 Homestead St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 54 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Berndt

6-DATE OF BIRTH (month, day and year) June 7.

7-AGE. 57 yrs. 3 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer). Iron Works

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. August Berndt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Louise Peter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Elizabeth Berndt Wife

(Address) 1758 Homestead St

15- Filed ....., 192.. ..... Registrar.

P2 61924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24/24

17- I HEREBY CERTIFY, That I attended deceased from Nov ....., 1923 to Sept 25 1924

that I last saw h.. alive on Sept 24 1924

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

.....

.....

.....

Approximately (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) A. J. Underhill, M. D.

....., 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Sept 27 1924

20-UNDERTAKER. Hyattstown M. Funeral Home ADDRESS 1111 W. Baltimore St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90542

185

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1069 W. Fayette St., 16th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Karl Wilhelms

(a) Residence No. 1069 W. Fayette St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of Caroline Wilhelms

6-DATE OF BIRTH (month, day and year) March 16 183[illegible]

7-AGE. 87 yrs. 6 mos. 10 ds. If LESS than 1 day, ~~hrs.~~ ~~min.~~

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Porchom Germany

PARENTS.

10-NAME OF FATHER. Fredk Wilhelms

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Charlotte

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Helmuth Wilhelms

(Address) 1069 W. Fayette St.

15- Robert P. Harrison, Registrar.

SEP 26 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26/24

17- I HEREBY CERTIFY, That I attended deceased from August 30, 1924, to Sept 25, 1924, that I last saw h[illegible] alive on September 25, 1924, and that death occurred, on the date stated above, at 11-30 ~~P~~ A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Fracture Hip

and old age (Duration) One mos. [illegible] ds.

18-Where was disease contracted if not at place of death? at his home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Thomas Emmons M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 29 19[illegible]

20-UNDERTAKER, Lloyd Smith — ADDRESS 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90543

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise I. Hemmell

(Residence in Baltimore: No. 1201 W. Mulberry Street St.; yrs., lifmos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. October 19th (Month) (Day) 1858 (Year)

7-AGE.	If LESS than 1 day,
65 yrs. 11 mos. 5 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Richard S. Pryor

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Sarah G. White

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Miller

(Address) 409 N. Carey Street

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24th (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows: Auto Accident

Fractures of Skull & Contusions

(Duration) hrs. yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

9-25 1924 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Sept 27 1924

20-UNDERTAKER. Robt B. Cook ADDRESS 1003 W. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT, WITH ENDORSEMENT THEREON, IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be made CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17386 90544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1350 90544

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST., 1 WARD)

2-FULL NAME Clayton Ranch

(a) RESIDENCE NO. Johnstown Pa. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Weight Master
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: Bethlehem Steel Co.

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER Henry Ranch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER Julia Kimmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Record Johns Hopkins Hosp

15 Filed ..... 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th, 1924, to Sept 26, 1924, that I last saw him alive on Sept 26, 1924, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure — cardio-vascular renal disease

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Urinary infection (duration) 0 yrs. 3 mos. ? ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? Yes Date of 9-6-24

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Urea, Bacteriology

(Signed) Eugene L. Thaw, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnstown, Pa.
DATE OF BURIAL: 9/26/1924

20 UNDERTAKER: C. J. Fanning & Son
ADDRESS: 1986 Lafayette Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86-001 D 90545

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Barber

(a) RESIDENCE NO. 957 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffer 6 2 13

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hospital Record
(Address)

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/24

17 I HEREBY CERTIFY, That I attended deceased from 9/15/24, 19..... to 9/23/24 that I last saw h alive on 9/23/24 and that death occurred, on the date stated above, at 3.55 P.M.

The CAUSE OF DEATH* was as follows:

Otitis Media.

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) General Abscess

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes, Date of 9/18/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) H. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicsville Md Mays Co.

DATE OF BURIAL 9/27/24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Penna Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Cook

(a) Residence No. 314 Diamond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1855

7-AGE, 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

SEP 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-24-24

17- I HEREBY CERTIFY, That I attended deceased from 9-3, 1924 to 9-24 1924

that I last saw her alive on 9-24, 1924

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Jones, M. D.

(Address) Municipal Hospital

9-24, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 1924
Mt Auburn Cem	9/27
20-UNDERTAKER, David Easton	ADDRESS 916 Penna ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90547

HEALTH DEPARTMENT—CITY OF BALTIMORE

111,001 ✓ D 90547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Kleinfelter

(a) Residence No. 809 Forest St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 20, 1869

7-AGE. 55 yrs. 0 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER, George Kleinfelter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Schaffer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Md

14- (Informant) Minnie A. Klinefelter

(Address) 811 Forest St

15- Sept 27, 1924 Robert P. Harrison, Registrar.

N.B. P 2 6 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-24-24

17- I HEREBY CERTIFY, That I attended deceased from 9-20, 1924 to 9-24, 1924

that I last saw him alive on 9-24, 1924

and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach (Pylorus)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 2 days ago

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Wilson M. D.

9-25, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Irvine — DATE OF BURIAL. Sept 27, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Hartford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90548

CERTIFICATE OF DEATH.

D 90548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2850 N. Charles ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. H. Watts

(a) RESIDENCE NO. 2850 N Charles ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Watts

6 DATE OF BIRTH (month, day, and year) Dec 25, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Frank D. Watts (Address) 2850 N. Charles St.

15 Filed ..... 19 .....

Registrar

SEP 26 1924

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Sept 25, 1924, that I last saw ~~alive~~ on Sept 24, 1924 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Sim, M. D.

9/26, 1924 (Address) 6774 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Sept. 29, 24

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS North Pa

Spec.—1-10-21 M&T 1500 Bks.

D 90549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 N. Charles ST., 17 WARD)

2-FULL NAME Anna ~~Foster~~ Fort Sanders

(a) RESIDENCE NO. 2212 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of David Henry Sanders.

6 DATE OF BIRTH (month, day, and year) Sept 14, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	80		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housewife~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burlington, N. J.

PARENTS

10 NAME OF FATHER Samuel Fort

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Elizabeth Keeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Evelyn E. Sanders

(Address) 2212 N. Charles St. Balto. Md.

15 Filed SEP 26 1924, 19 Robert P. Harrison, Registrar

1 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jany 27, 1920 to Sept. 25, 1924.

that I last saw h alive on Sept. 24, 1924,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - (Primarily in breast & metastasis)

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Toxaemia -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George Abner Bowden, M. D.

9/25, 1924 (Address) 1517 E. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Sept 27 1924

20 UNDERTAKER Wm J. Pickett & Sons ADDRESS North Ave

MARRIAGE RESERVED FOR BRIDE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George S. Zouck

(a) Residence No. 2816 Pennsylvania St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1844

7-AGE 80 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer National Coconut Co

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Records

(Address)

15- 192

Robert P. Harrison, Registrar.

SEP 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-26-24

17- I HEREBY CERTIFY, That I attended deceased from 9-25, 1924, to 9-26, 1924 that I last saw him alive on 9-25, 1924 and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Cerebral Hemorrhage

(Duration) yrs. mos. 12 hr.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ob

(Signed) Claude S. Dean M. D.

9-26, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem	Sept 27 1924
20-UNDERTAKER.	ADDRESS
Wm Hickenbottoms	North Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90551 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90551

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto Genl. Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Lippincott Reese

(Residence in Baltimore: No. Arundel Apts St.; yrs. Liv mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. January (Month) 11 (Day) 1877 (Year)

7-AGE. 47 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Business
(b) General nature of industry, business, or establishment in which employed (or employer): Reese Reese Co

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Harry S. Reese

11-BIRTHPLACE OF FATHER. (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER. Ida Belle Lippincott

13-BIRTHPLACE OF MOTHER. (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H S Reese (Brother)

(Address) Arundel Apts.

15- Filed SEP 27 1924 19 Robert P. Harrison, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 25 (Day) 24 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Res. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pect.

Duration yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) H. Ellwood Blades M. D. (Coroner)

(Address) 412 N. Paca

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death 0 yrs. 0 mos. few minutes ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Arundel Apts.

19-PLACE OF BURIAL, OR REMOVAL. Druid Ridge Cemetery

DATE OF BURIAL. Sept 27th 1924

20-UNDERTAKER. STEWART & WOODEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than 1 day, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Example is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90552

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Falls Road 937 S. ... St., ... Ward) 12

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Poole Hooper

(a) Residence No. St Paul 2nd 2325 St., ... Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 8 mos. 26 ds. How long in U. S., If of foreign birth? 81 yrs. 8 mos. 26 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Hooper

6-DATE OF BIRTH (month, day and year) Dec-31-1842

7-AGE 81 yrs. 8 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ... none

(b) General nature of Industry, business, or establishment in which employed (or employer) ... none

(c) Name of employer ... none

9-BIRTHPLACE (city or town). Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Robert Poole

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Ann Simpson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-

(Informant) Mr. Jas. P. Hooper (Son)

(Address) Ruxton-Md.

15-

Filed ... Robert P. Harrison, Registrar.

SEP 27 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept-26-1924.

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1924, to Sept 25th, 1924, that I last saw h... alive on Sept 25th, 1924, and that death occurred, on the date stated above, at 1.00 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? do

Did an operation precede death? ... Date of ...

Was there an autopsy? do

What test confirmed diagnosis? signs & symptoms

(Signed) J. A. Blackard, M. D.

Sept 26, 1924 (Address) 130 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Sept 27 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODER, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCL... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90553

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 B 901 90553

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Cathedral St. ST., 11 WARD)

2-FULL NAME Frank Bernard Cassidy.

(a) RESIDENCE NO. 1215 Cathedral St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced
HUSBAND of Estelle Stewart Cassidy.

6 DATE OF BIRTH (month, day, and year) August 11, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manager,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Stewart Taxi Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Cassidy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Callan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mildred Cassidy. (daughter)
(Address) 1215 Cathedral St.

15 Filed SEP 27 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 25, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. C. Reinhardt, M. D.
(Coroner.)

Sept. 25, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathederal Cemetery — DATE OF BURIAL: Sept-29-24

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 106 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONSULTATION is very important. See instructions on back of certificate.

DARKOW

Spec.—5-19-13—M. & T.—500 Bks.

D 90554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90554

CERTIFICATE OF DEATH.

113

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 Andre St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gibson (Schmitz)

(Residence in Baltimore: No. 1350 Andre St.; ....yrs.,....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 16 (Day), 1924 (Year)

7-AGE, ...yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Julia Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Russia - Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Gibson

(Address) 1350 Andre St.

15- Robert P. Harrison, ...191.... Registrar.

SEP 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1924, to Sept. 25 1924, that I saw h— alive on Sept. 24 1924, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia - Lobular

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. S. Bruce M. D.

9-26, 1924 (Address) 516 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Sept 27 1924

20-UNDERTAKER H. Jackson 164 — ADDRESS Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.-12-23-21—E.B.R.S.—400 Blks.

D 90555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90555

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1507 Pennsylvania Ave St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John E. Cotter

(a) Residence No. 1507 Pennsylvania Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 17 1924

7-AGE.	If LESS than 1 day,
....yrs. 3 mos. 9 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Cotter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Ida Delsa

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) Ida Cotter

(Address) 1507 Pennsylvania Ave

15-

Filed SEP 27 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1924 to Sept 26 1924

that I last saw h~~im~~ alive on Sept 25 1924

and that death occurred, on the date stated above, at 3.40 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

6

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Tillow M. D.

9/26, 1924 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Trinity Cem	Sept 27, 1924
20-UNDERTAKER. John Ulrich	ADDRESS 2005 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90556 D 90556

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Jefferson ST., 6 WARD)

2-FULL NAME Cortilda Navratil

(a) RESIDENCE NO. 1725 Jefferson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 12-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work tailor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Silver Navratil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Rock.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Taylor.
(Address) 1725 Jefferson St.

15 Filed SEP 25 1924, 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924.

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1924, to Sept 24, 1924, that I last saw her alive on Sept 24, 1924, and that death occurred, on the date stated above, at 11:56 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? [redacted]

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum & Physical Signs

(Signed) Chester Ruland, M. D.

9-24, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Sept 27 1924

20 UNDERTAKER John Ulleriat

ADDRESS 2008 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D 90557

HEALTH DEPARTMENT—CITY OF BALTIMORE

90557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Aubrey

(a) RESIDENCE NO. 1715 N. Port ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Amelia Aubrey

6 DATE OF BIRTH (month, day, and year) Oct 17, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Presley Aubrey

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Don't Know.
(State or country)

14 Informant Amelia A Aubrey
(Address) 1715 N Port St

SEP 27 1924 , 19 Robert P. Garrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Sept 26, 1924, that I last saw him alive on Sept 26, 1924, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Prostatectomy 9/24/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical data

(Signed) A. L. Manning, M. D.

Sept 25, 1924 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Sept 29 1924

20 UNDERTAKER John Ullrich

ADDRESS 208 E Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90558

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 Saxe St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter H Dennick

(a) Residence No. 904 S 2nd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 2/1922

7-AGE, 2 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John H Dennick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mollie Siebert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) John H Dennick

(Address) 904 S 2nd

15- Robert P. Harrison,

SEP 27 1924 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 24th, 19 24 to Sept 26th, 19 24

that I last saw him alive on Sept 25th, 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Jarvis M. D.

9-26-, 1924 (Address) 1011 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem — DATE OF BURIAL, Sept 27, 1924

20-UNDERTAKER, John Merrick — ADDRESS 2008 Orleans.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90559

D 90559

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 E. Church ST.: 7W WARD)

2-FULL NAME William E. Harris

(a) RESIDENCE. No. 46 E Church ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Harris

6 DATE OF BIRTH (month, day, and year) Nov 26-1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 10 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Remington Md.

PARENTS

10 NAME OF FATHER DK

11 BIRTHPLACE OF FATHER (city or town) (State or country) DK

12 MAIDEN NAME OF MOTHER Jane Thalins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) DK

14 Informant Mary E. Harris (Address) 46 E Church

15 Filed SEP 27 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1924, to 9/25, 1924, that I last saw h[illegible] alive on 9/25, 1924, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Edw. Smith, M. D.

9/26, 1924 (Address) 910 Eight St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Remington Md	Sept 28 1924
20 UNDERTAKER	ADDRESS
J. E. Brown & Son	1616 Monroe St
PRR - Pennsylvania RR	

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH should be stated EXACTLY. Exact statement of cause of death in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90560

CERTIFICATE OF DEATH.

90 D 90560

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 7 St. nr. 2nd. Ave. Fairfield. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Jones. (C)

(a) RESIDENCE No. 7 St. nr. 2nd. Ave. Fairfield. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 17, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore Tube Co.

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER William Jones. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Eliza Russell (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Virginia Tucker. (C) sister.
(Address) 7th. St. nr. 2nd. Ave. Fairfield

15 Filed SEP 27 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 25, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 25, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 28 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Edmondson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90561

1-PLACE OF DEATH Johns Hopkins

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda Langford

(a) RESIDENCE NO. 2483 Druid Hill ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Langford

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Maude Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant .....

(Address) .....

15 SEP 27 1924 Robert P. Harrison, ... 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1924, to Sept 24, 1924, that I last saw h... alive on Sept. 24, 1924, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund H. Kerper, M. D.

9/25, 192 4 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL ..... 19 .....

20 UNDERTAKER ..... ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stasc. 6-9-19—H. P. Co.—1000 Bks.

D 90562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2110 Etting ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Thomas

(a) RESIDENCE. No. 2110 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Henry Sydnor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Celia Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lewis Thomas (Address) 2110 Etting St

Filed .19 Robert P. Harrison, Registrar

Burial Permit Clerk.

EP 2 71924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24 24

17 I HEREBY CERTIFY, That I attended deceased from 8/20 .19 24 . to 9/24 .19 24 .

that I last saw her alive on 9/24 19 24 ,

and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Ac. Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkbetty, M. D.

9/25-19 24 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 25 1924

20 UNDERTAKER Lauder Hennessy ADDRESS 1018 Eutaw

WARNING—RESERVED FOR STATISTICS

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90563 D 90563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Judy

(a) RESIDENCE No. 224 East E St ST., Sparrows Point WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Judy

6 DATE OF BIRTH (month, day, and year) April 17, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
62	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipyard helper

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER William Judy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Clyper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Records (Address)

Filed SEP 27 1924, 19 Burial Permit Issued. Registry

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Sept 26, 1924, that I last saw h alive on Sept 26, 1924, and that death occurred, on the date stated above, at 1 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Cancer)

(duration) 4 yrs. ? + mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) A C Manninger M. D.

Sept 26 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Sept 29 1924

20 UNDERTAKER John H. Denny ADDRESS 715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS about to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 7 S. Fifth St. Brooklyn ST., 25 WARD)

2-FULL NAME Stephen W. Gatton.

(a) RESIDENCE NO. 7 S. Fifth St. Brooklyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Rebecca S. Gatton.

6 DATE OF BIRTH (month, day, and year) September 18, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Prudential Oil Co.

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER John W. Gatton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Mary J. Newton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Rebecca S. Gatton (wife) (Address) 7 S. Fifth St. Brooklyn.

15 Filed ..... 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Sept. 25, 1924 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 27 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90565

CERTIFICATE OF DEATH.

9 / D 90565

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Bank ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Alice Schreiber

(Residence in Baltimore: No. 2105 Bank St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, October 20, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Robert E. C. Lee Schreiber

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Anne Mary Dromgoole

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. C. Lee Schreiber

(Address) 2105 Bank St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

SEP 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1924, to Sept 26 1924, that I saw h.. alive on Sept 26 1924, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (Duration) ....yrs. ....mos. 16 ds.

(Signed) [illegible] M. D.

Sept 26, 1924. (Address) 3 E Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cem.	Sept. 27th, 1924
20-UNDERTAKER	ADDRESS
Lilly - Zeiler	403 S Wolfe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 90566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90566

CERTIFICATE OF DEATH.

74-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Augusta Ave. ST., W WARD)

2-FULL NAME Mary P. Koontz

(a) RESIDENCE NO. 307½ Augusta Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 0 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Koontz

6 DATE OF BIRTH (month, day, and year) ~~Sept 26 1832~~ June 2, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	92			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmittsburg Md

PARENTS

10 NAME OF FATHER Richard Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Martha Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frad. Co Md

14 Informant (Address) Mrs A Koontz 307 Augusta Ave

15 Sept 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 26, 1924, that I last saw h[illegible] alive on Sept 26, 1924, and that death occurred, on the date stated above, at 1245 Pm.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis -

Cerebral Thrombosis -

Hemiplegia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Old Age

(duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) 222 Augusta Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Sept 29 1924

20 UNDERTAKER George J Smith — ADDRESS 1532 Holliday St

P 2 7 1924

U. S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 529 Ravenswood Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Dritt

(a) Residence No. 529 Ravenswood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	W.	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of David E Dritt

6-DATE OF BIRTH (month, day and year) July 16, 1863

7-AGE. 61 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 07
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER, John Rice

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14-Informant, Claude R Dritt

(Address) 529 Ravenswood Ave

15-Filed SEP 27 1924, 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Sept 11th 19 24 to Sept 25th 19 24, that I last saw h.. alive on Sept. 25th 19 24 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Church Home.

What test confirmed diagnosis? X Ray & blood tests

(Signed) Charles A. Meyer M.

9/26, 1924 (Address) 1031 N. Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Sept 27, 1924
Woodlawn	
20-UNDERTAKER, W. M. Cook	ADDRESS 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec– 12-23-21–E.B.R.S.–400 Bks.

Dr Shellman 6 E Biddle St

D 90568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90568

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1723 West North Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Clark

(a) Residence No. 1723 West North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Irene Clark

6-DATE OF BIRTH (month, day and year) July 22. 1870

7-AGE. 54 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER Wm H Clark

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country).

14- (Informant) Irene Clark

(Address) 1723 W North Ave

15- Filed ....., 19.... Robert P. Garrison, Registrar.

Deputy Female Clerk

P 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26 1924

17- I HEREBY CERTIFY, That I attended deceased from June 20th 19 24 to Sept 26th 19 24

that I last saw him alive on Sept 20th 19 24

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 29, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hubert F Shellman M. D

19 (Address) 6 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Md — DATE OF BURIAL. Sept 29, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E North Ave.

FORM B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90569

174226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 90569

1-PLACE OF DEATH John Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pete Powell

(a) RESIDENCE NO. 1[illegible] Wilson ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Emma Powell

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) N. C.

PARENTS

10 NAME OF FATHER Edward Powell

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Betty Lawson

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country) N. C.

14 Informant .....
(Address) [illegible]

15 SEP 27 1924 , 19 Robert F. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Sept 27, 1924, that I last saw h[illegible] alive on Sept 27, 1924, and that death occurred, on the date stated above, at 10:05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lung

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY
(Secondary) —— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? By Autopsy

(Signed) Louis C. Marlow M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. C.

DATE OF BURIAL Sept 28 1924

20 UNDERTAKER Chas H. Johnson

ADDRESS [illegible] N. Carolina St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90570

CERTIFICATE OF DEATH.

D 90570

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. Paul Ward) 19

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Archer

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Not Known ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced (Write word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1865 day & mo. known

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Texas

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) A. Patterson

(Address) Bay View Hosp.

15- Robert P. Garlach,

19 Registrar.

SEP 27 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-24-24

17- I HEREBY CERTIFY, That I attended deceased from 9/17/24 to 9/24/24

that I last saw him alive on 9/24/24

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Extensive carbuncle of upper lip

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/23/24

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) Claude S. Thomas M. D.

9-24 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Cemetery DATE OF BURIAL. 9/25/24 19

20-UNDERTAKER. Clark & Lawson ADDRESS 46 N. Carolina St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90571

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001 D 90571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary V REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Schreiber

(a) RESIDENCE NO. 2022 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Tin factory

(c) Name of employer Tin Plate Mfg. Co. Baltimore

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Christian Schreiber

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Dead (State or country)

14 Informant Christian Schreiber

(Address) 2022 Fleet St. City

15 Filed SEP 27 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1924, to Sept. 26, 1924, that I last saw him alive on Sept. 26, 1924, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Cavernous Sinus Thrombosis

Streptococcus Septicemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Meningitis (?)

(duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Blood culture —

(Signed) C. W. Saunders, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn DATE OF BURIAL Sept 30 1924

20 UNDERTAKER Jerkler & Birkler ADDRESS 1739 Eager

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 90572

D 90572

CERTIFICATE OF DEATH

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Boy View Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stratton Hamlet

(a) Residence No. 624 Myrtle Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

~~5-Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do

14- (Informant) Boy View Hospital

(Address)

Filed SEP 27 1924, 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1924 to Sept 24, 1924

that I last saw h[illegible] alive on Sept 23, 1924

and that death occurred, on the date stated above, at 2.25 P.M.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the insane)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyuria-Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) H. Rockwell Long M. D.

9/27, 1924 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 1924

20-UNDERTAKER. Robert P. Harris. ADDRESS Commissioner Health,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

1813

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90573

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME...william patterson.....

(a) Residence No. St. Elizabeth's School St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1913

7-AGE.	If LESS than 1 day.
11 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, William patterson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 3 1923 to Sept. 26, 1924 that I last saw him alive on Sept. 26 1924 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
T. B. osteomyelitis of
hip, knee, with amputation (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Richard Schorr M. D.

9-26-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
	19

20-UNDERTAKER.	ADDRESS

Robert P. Harrison, Director of Public Health and Charities

Dr. Wm. H. Woodall

1812

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90574

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., [illegible] Ward)

Registered No. 100

2-FULL NAME. John J. Buck

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Boys Town Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE,	If LESS than 1 day,
65 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14-

(Informant) Municipal Hospital Records

(Address)

15-

Filed ..... 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-25-24

17- I HEREBY CERTIFY, That I attended deceased from 2-7, 1924 to 9-25, 1924

that I last saw him alive on 9-25, 1924

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Draper, M. D.

9-25, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Interred and buried	1924
20-UNDERTAKER.	ADDRESS
Greenmount Cem. (Chas H. Johnson)	Oct 1924 4/6 N. Caroline St

SEP 27 1924

1811

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

UNIVERSITY OF MARYLAND
Robert P. Garrison
SEP 30 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90575 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90575

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 2540 Foster Ave St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Fibich (Baby)

(a) Residence No. 2540 Foster Ave. St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, — Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 9, 1922

7-AGE.	If LESS than 1 day,
1 yrs. 9 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md.
(State or Country)

PARENTS:

10-NAME OF FATHER, Frank Fibich

11-BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Bunk

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country),

14-

(Informant) Mr. Frank Fibich

(Address) 2540 Foster ave

15-

Filed Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 22, 1924 to Sept 26, 1924 that I last saw him alive on Sept 25, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Ileo-Colitis

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.M.

(Signed) John J. Kluger M. D.

, 19 (Address) 2627 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Sep 27 1924
20-UNDERTAKER.	ADDRESS
John A Weber	1803 Bank St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P2 71924

Spec– 12-23-21—E.B.R.S.—400 Bks.

B 90576

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 90576

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Ridgely St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Kreipel

(a) Residence No. 1135 Ridgely St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Single~~ Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 15-1924

7-AGE. yrs. 4 mos. 11 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work /

(b) General nature of Industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:

10-NAME OF FATHER, Leo J. Kreipel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Elizabeth R. Wagner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) Leo J. Kreipel

(Address) 1135 Ridgely St.

15- Filed Sept 21 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26th 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1924 to Sept 25 24

that I last saw h[illegible] alive on Sept 24 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 5 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas A Dixon M. D

, 19 (Address) 2027 South Bl[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem.	Sept 27 1924
20-UNDERTAKER.	ADDRESS
F. C. Krause & Son	763 Hanover St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1998 90577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X84 D 90577

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell D Wood

(a) RESIDENCE NO. Finksburg Carroll Co Md WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE: Years 19 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm C. Dunfall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Betty Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friend

(Address) 1 Hill St

15 Filed SEP 27 1924 . 19 ..... Robert P. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 . 1924 . to Sept 26 . 1924 .

that I last saw him alive on Sept 26 . 1924 .

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor — benign

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? Yes Date of Sept 26-24

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Warfield M Theon M. D.

. 19 (Address) 914

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Freedom Md. DATE OF BURIAL: Sept 28 1924

20 UNDERTAKER: A H Weer ADDRESS: Sykesville

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90578

REGISTERED NO. 179 D 90578

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST., 4 WARD)

2-FULL NAME John H. Brown

(a) RESIDENCE NO. 113 W. Mulberry St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 130

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane B. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rec'd
(Address) 3 Hk Co

15 SEP 27 1924 Robert P. Harrison, ..., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 —, 1924, to Sept 26 —, 1924, that I last saw h— alive on Sept 26 —, 1924, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm Osler, M. D.

19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 9/29/24

20 UNDERTAKER H. E. Hughes 4247 ADDRESS Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 90579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 90579

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Beatrice Chaney

(Residence in Baltimore: No. 1515 Lamont Ave St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH. June 25th, 1898 (Month) (Day) (Year)

7-AGE. 26 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Attendant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hospital

9-BIRTHPLACE. (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Harry Chaney

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Bertha Chaney

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bertha Chaney, (Mother)

(Address) 209 Elizabeth St, Hagerstown Md

15- Robert P. Harrison, Registrar.

SEP 27 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26th, 1924 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bichloride mercury poisoning
suicide. (Entered Johns Hopkins
Hospital Sept 17th, 1924. Autopsy
at Hospital Sept 27th, 1924
(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs....mos.....ds.

(Signed) J. S. H. Potter M. D. (Coroner.)

Sept 27th, 24 (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hagerstown, Md

DATE OF BURIAL, 9-30, 1924

20-UNDERTAKER C. M. Suter & Sons.

ADDRESS Hagerstown, Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 90580 ✓ X 49 D 90580

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Precious

(a) RESIDENCE No. 273 Curtis St ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robina

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Precious

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Eanfrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Record Johns Hopkins Hospital

Filed SEP 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1924, to Sept 27, 1924, that I last saw h alive on Sept 27, 1924, and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:

Brain tumor - malignant

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N.Y.

Did an operation precede death? Yes Date of Sept 15-24

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield McFires, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rochester N.Y. — DATE OF BURIAL Sept. 27 1924

20 UNDERTAKER Wm C. Black — ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., | WARD)

2-FULL NAME Richard Grice

(a) RESIDENCE NO. 772 Fountain St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Morton Grice

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ruby Needle

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Record
(Address)

15 Filed SEP 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Sept 26, 1924,

that I last saw him alive on Sept 26, 1924,

and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary-unidentified)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

9/27, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Grace Md	9-27 1924
20 UNDERTAKER E & B. Hale	ADDRESS 15 E. Hunt St

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90582

CERTIFICATE OF DEATH.

D 90582

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Genevieve Dowling~~ 1602 E. Fort Ave St., 24th Ward)

Registered No. 9

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME ~~Genevieve Dowling~~ Genevieve E. Dowling

(a) Residence No. 1602 E. Fort Ave St., Ward 24
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 30 1913

7-AGE. yrs. 10 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Andrew Dowling

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Catherine Dowling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Catherine Dowling

(Address) 1602 E. Fort Ave.

15- SEP 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-27-1924

17- I HEREBY CERTIFY, That I attended deceased from 8-1-, 1924 to 9-27-, 1924 that I last saw her alive on 9-27-, 1924 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

9-27, 1924 (Address) 20 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cemetery Md. DATE OF BURIAL, Sept 28. 1924

20-UNDERTAKER. A. Howard Evans ADDRESS 38 E Fort Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 90583

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ostritsky

(a) RESIDENCE No. 919 Watson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Ostritsky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Ostritsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Shana Rodkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Meyer Ostritsky (Address) 919 Watson

15 Date SEP 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/15 ..., 19 24, to 9/27 ..., 19 24, that I last saw him alive on 9/25 ..., 19 24 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Cardiac failure

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/22/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Philip Harrison M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Rosedale	9-28-1924

20 UNDERTAKER Jack Levin, ADDRESS 429 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90584

CERTIFICATE OF DEATH.

179

D 90584

1-PLACE OF DEATH

City of BALTIMORE: (No.) 124 S. Eden Street St., 3 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Samuel Brooks

(a) Residence No. 124 S. Eden St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Brooks

6-DATE OF BIRTH (month, day and year) May 10 1860

7-AGE. 63 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Tyre

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Abraham Brooks

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rivi

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14-

(Informant) Jack Lewis

(Address) 1439 E Balto St

15-

SEP 28 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 27/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 24 1924 to Sept 27th 1924

that I last saw him alive on Sept 27th 1924

and that death occurred, on the date stated above, at 6.30a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. 3 mos. ds

CONTRIBUTORY (Secondary) Nephritis and Bronchitis chronic

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) A. F. Rees, M. D.

. 19 (Address) 24 S Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville Wash. Road

DATE OF BURIAL. 9-28- 1924

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 E Balto

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—This

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65 B 90585

B 90585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Stern

(a) RESIDENCE NO. 136 N. Ann St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roumania

12 MAIDEN NAME OF MOTHER Rose Jeff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Louis Stern

(Address) 136 N. Ann St.

15 Filed SEP 28 1924, 19 ROBERT R. KRAUTER, Social Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1924

17

I HEREBY CERTIFY, That I attended deceased from 9-5-24, 19.... to 9-27, 1924, that I last saw h/m alive on 9-27, 1924 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. 4 mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor S. Frey M. D.

Sept. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Rd. DATE OF BURIAL 9-28-1924

20 UNDERTAKER Jack Lewis, 1439 E. Balto. ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stauffer.

D 90586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90586

1-PLACE OF DEATH U.S. Marine Hospital No 4 Baltimore Md

CITY OF BALTIMORE: (No. 21 ft Lexington ave. ST.) (WARD 1)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Stauffer

(a) RESIDENCE NO. U S Marine Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mate (Seaman)

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman. 086

(c) Name of employer S/S Catahoula

9 BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10 NAME OF FATHER Un known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un known

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un known

14 Informant Self U. S. M. H.
(Address) Hosp Grounds

15 SEP 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1924, to Sept 24, 1924, that I last saw him alive on Sept 24, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Nephritis, Parenchymatous
Chronic

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Anemia Gravis (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Un known.

Did an operation precede death? Yes Date of 9/19/24.

Was there an autopsy? Yes

What test confirmed diagnosis? Physical test and Laboratory W. R. & Kahn

(Signed) ..... M. D.

19 , 19 (Address) U-S Marine Hospital #1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL 9/28/24

UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Belte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90587

CERTIFICATE OF DEATH.

D 90587

1-PLACE OF DEATH U.S Marine Hospital No 1. REGISTERED NO.....

CITY OF BALTIMORE: (No. Baltimore Md ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Carlson.

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., If of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) Dredge 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS

10 NAME OF FATHER Unknown
Brother Fay Carlson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Self U.S.M. Hosp. Records
(Address)

15 Filed SEP 28 1924 ROBERT N. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924.

17 I HEREBY CERTIFY, That I attended deceased from August 19 1924. to September 27. 1924.
that I last saw him alive on September 27 1924.
and that death occurred, on the date stated above, at 1 15 am

The CAUSE OF DEATH* was as follows:

Tuberculosis, Chronic
pulmonary.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Physical findings & Laboratory findings.

(Signed) M. A. Snider, M. D.

9/27 1924 (Address) U.S. Marine Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery. DATE OF BURIAL 9/28 1924

20 UNDERTAKER Sol Levinson & Bro ADDRESS E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A. • SURVEY

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90588

CERTIFICATE OF DEATH.

38 D 90588

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Fuller

(a) Residence No. 1143 Mary St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1877

7-AGE. 47 yrs. mos. ds. If LESS than 1 day hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed SEP 28 1924 ROBERT N. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-25-24

17- I HEREBY CERTIFY, That I attended deceased from 8-28 1924 to 9-25 1924 that I last saw h[illegible] alive on 9-25 1924 and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis

Aneurysm of thoracic aorta

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Charles S. Dorsey M. D.

9-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cemetery — DATE OF BURIAL. Sept 27 1924

20-UNDERTAKER. Edward Bryan — ADDRESS 631 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 90589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Durham ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Darkins

(a) RESIDENCE No. 417 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX fenil 4 COLOR OR RACE colord 5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
99				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Williams smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER mary thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant mary thompson (Address) 417 N. durham st

15 Filed SEP 28 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-1924

17 I HEREBY CERTIFY, That I attended deceased from 3-5-, 1924, to 9-26-, 1924, that I last saw her alive on 9-25-, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pentonitis

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Hargett, M. D.

9-27-1924 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury Cemetery

DATE OF BURIAL 29 Sept 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90590

B 90590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (John Hopkins Hospital)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Sheckles

(a) RESIDENCE NO. 512 Dukeland ST., ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) ... Maryland
(State or country)

PARENTS

10 NAME OF FATHER ... Howard Sheckles

11 BIRTHPLACE OF FATHER (city or town) ... Md.
(State or country)

12 MAIDEN NAME OF MOTHER ... Nellie Lamb

13 BIRTHPLACE OF MOTHER (city or town) ... Md.
(State or country)

14 Informant ... Parents
(Address) ... 512 Dukeland

15 SEP 28 1924 ROBERT A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1924, to Sept 26, 1924,

that I last saw h... alive on Sept 26, 1924,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Edmund A Kerper, M. D.

9/27, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Sept 29 1924

20 UNDERTAKER Wm Cook ADDRESS 3022 Gorsuch Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90591 ✓ 90591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 128 S Durham St., V Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Wm T Hartlove

(a) Residence No. 128 S Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sarah Hartlove

6-DATE OF BIRTH (month, day and year): April 14, 1873

7-AGE: 51 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoffer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: George R Hartlove

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Elizabeth Engle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-
(Informant): Sarah Hartlove
(Address): 128 S Durham St

15-
SEP 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1924, to Sept 26 1924, that I last saw h.im alive on Sept 26 1924 and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic parenchymatous nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Ur urinalysis

(Signed) A Palmisano, M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Sept 29 19 24

20-UNDERTAKER: Wm Cook — ADDRESS 502 E Hoffman Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90592

D 90592

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1305 Monroe St., (Hospital) (WARD)

2-FULL NAME John H. Helsinger Jr

(a) RESIDENCE No. 1308 W Lanvale St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Musician
(b) General nature of industry, business, or establishment in which employed (or employer): Seaman
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER John H. Helsinger

11 BIRTHPLACE OF FATHER (city or town) Da
(State or country)

12 MAIDEN NAME OF MOTHER Jane Wheatley

13 BIRTHPLACE OF MOTHER (city or town) Da
(State or country)

14 Informant: Mrs John H. Helsinger
(Address) 1308 Lanvale St

SEP 28 1924

ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas
Duc to Gallstones
Gallstone Cholecystitis

Patient (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)

Sept 27, 1924 (Address) 3622 Roland Ave

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Sept 29 1924
20 UNDERTAKER	ADDRESS
Jos Poesdens Son	217 S. Bro

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90593

CERTIFICATE OF DEATH.

1884 D 90593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. B & O R.R. Hosp. Lot) ST., 116 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Murray D Plain

(a) RESIDENCE NO. 1638 Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work B & O R.R. Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) R.R. 83
(c) Name of employer B & O R.R. Co

9 BIRTHPLACE (city or town) Frederick Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Plain

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country)

12 MAIDEN NAME OF MOTHER Anna Eyler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14
Informant Geo D Plain
(Address) 1638 Baltimore

Filed SEP 28 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Internal Injuries

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D.
(Coroner.)

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 29 1924
20 UNDERTAKER Jos Joerdens Son	ADDRESS 217 S. Bro

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 ✓

D 90594

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 924 N. Mount ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hawkins

(a) RESIDENCE No. 924 N. Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard N. Hawkins

6 DATE OF BIRTH (month, day, and year) June 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	39	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Friendship Md

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richard N. Hawkins

(Address) 924 N. Mount St.

15 Filed SEP 28 1924

ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 27, 1924, that I last saw her alive on Sept 27, 1924 and that death occurred, on the date stated above, at 930 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis ?

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. B. Hughes M. D.

1924 (Address) 1423 E. Fed Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Md | DATE OF BURIAL Sept 29 1924

20 UNDERTAKER Samuel E. Hawkins | ADDRESS Ellicott City Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

W 90595

74-001 D 90595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 220 N. Front St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Joseph Cohen (Cohen)

(a) Residence No. 220 N. Front St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Married Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Goldie Cohen

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Mens clothing

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Cohen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Annie Kapel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Ellis Kalm

(Address) Eastport Md

15- SEP 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st 19 24 to Sept 27 19 24

that I last saw h alive on Sept 27 19 24

and that death occurred, on the date stated above, at 9.45 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. 27 ds.

18-Where was disease contracted if not at place of death? Patas

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign

(Signed) Benj. N. Kadan M. D.

, 19 (Address) 2306 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Pikesville Rosedale	9-28-, 19 24
20-UNDERTAKER,	ADDRESS
Jos. Levin	1434 E. Bres.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90596

CERTIFICATE OF DEATH.

74 08 90596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 South Broadway ST., 3 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Stevens Gatechair

(a) RESIDENCE No. 8 South Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20th. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) South River

(State or country) N. J.

PARENTS

10 NAME OF FATHER Louis Gatechair

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Willet

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. J.

14 Informant Mary A. Gatechair

(Address) 8 South Broadway

15 Filed SEP 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25th. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to Sept 25, 1924, that I last saw him alive on Sept 25, 1924, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorage

(duration) yrs. 2 mos 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No, Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) E B Britton, M. D.

, 19 (Address) 3316 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	9/29/24 19

20 UNDERTAKER ADDRESS

H. E. Hughes, 424 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90597 · CERTIFICATE OF DEATH. X 44 D 90597

1-PLACE OF DEATH University Hospital 4 REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Mealey

(a) RESIDENCE NO. Richwood W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Mealey

6 DATE OF BIRTH (month, day, and year): Aug. 1883.

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Alleghany Co W. Va

PARENTS

10 NAME OF FATHER: Wm Beckett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Martha C Hastings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Edward E. Mealey

(Address): Richwood W. Va

15 Filed SEP 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Sep. 16, 1924, to Sep. 27, 1924, that I last saw her alive on Sep 27, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Metastasis to Liver

Malignant Cachexia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of Sep 23 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation + autopsy

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richwood, W. Va — DATE OF BURIAL: Sept 28 1924

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 108 W. Lombard.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90598

CERTIFICATE OF DEATH.

49 D 90598

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals at Bay side Ward) 13 a (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mitchell Arnold

(a) Residence No. 3904 Falls Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, ~~Divorced~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 27. 1898

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS

10-NAME OF FATHER. John F Arnold

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER. Mary F Diven

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) O Diven

(Address) Pond Run Hosp

15- Registrar.

SEP 28 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from 7/10 19 24 to 9/26 19 24 that I last saw him alive on 9/26 19 24 and that death occurred, on the date stated above, at 1 00 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right foot with metastatic involvement of skull & brain.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of about 1 yr ago

Was there an autopsy?

What test confirmed diagnosis Laboratory examination

(Signed) Claude A. Dean M. D.

9-26 19 24 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hampden

DATE OF BURIAL, Sep 29 19 24

20-UNDERTAKER. CHENOWETH & SON

ADDRESS 317 CHESTNUT AVE

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90599 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90599

CERTIFICATE OF DEATH

32

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bryan -

(a) RESIDENCE NO. 5212 Linden Heights ST., Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child -

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
3	yrs	8 mos	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: William Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Va

12 MAIDEN NAME OF MOTHER: Anna Christy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Wm A. Bryan

(Address) 5212 Linden Heights Ave

15 Filed SEP 28 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1924, to Sept 27, 1924.

that I last saw her alive on Sept 27-, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

Sept 13- (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) I. B. Whaley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemty

DATE OF BURIAL: Sept 30th 1924

20 UNDERTAKER: C. Carson Hennard

ADDRESS: 723 W Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1740 48 90600 — 90600 — 154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernie Poling

(a) RESIDENCE No. Eckhart, Md. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 14 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
2	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Howard Poling

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Ethel Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant ..... (Address) .....

SEP 28 1924 — ALBERT E. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 24, to Sept 27, 19 24, that I last saw h... alive on Sept 26, 19 24, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? Yes Date of Sept 27, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Exam

(Signed) Warfield M Furen M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parson W Va — DATE OF BURIAL Sept 28, 24

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 90601

CERTIFICATE OF DEATH.

129 B 90601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 E Fort ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine V Hall

(a) RESIDENCE. No. 535 E Fort Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of V. C. Hall

6 DATE OF BIRTH (month, day, and year) Mar 11 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

PARENTS

10 NAME OF FATHER Cornelius Oconnor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dwight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant V. C Hall
(Address) 535-E Fort ave

15 Filed SEP 28 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 5 1924 to Sept 27 1924, that I last saw h~~er~~ alive on Sept 27 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic int. nephritis

unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) W. M. Elliott Stigler, M. D.

9/27 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg W Va	9/30. 1924
20 UNDERTAKER Thos. F. Talley Sons	ADDRESS 1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90602

90 D 90602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Appleton ST., 18 WARD)

2-FULL NAME Anna Lavender

(a) RESIDENCE NO. 203 N. Appleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph J. Lavender

6 DATE OF BIRTH (month, day, and year): May 15th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank J. Lavender

(Address): 203 N. Appleton St.

15 Filed ..... 19 ..... ROBERT N. KRAUTH Registrar

SEP 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8 1924 to Sept 25 1924

that I last saw her alive on Sept 25 1924

and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon Testa M. D.

, 19 (Address) 210 Park st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Sept. 29th 1924

20 UNDERTAKER: H. C. Brauns & Son

ADDRESS 514 N. Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

17-5-18

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

D 90603

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp WARD 28)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Kellie Knabe

(a) RESIDENCE No. Frederick Ave - Athol St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 8 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Gustav Schlene

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: L. Kennard Brown

(Address) Towsontown Md

15 Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1924 to Sept 26 1924, that I last saw her alive on Sept 26 1924, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Congenital Cystic Kidneys &
Bilateral Pyelonephritis.

Life (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) [illegible] M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 29 1924
20 UNDERTAKER: Henry W Jenkins Sons Co	ADDRESS: Orchard & Hartford Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90604

CERTIFICATE OF DEATH.

D 90604

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Frederick Road & Athold Ave St., 28 WARD)

2-FULL NAME Ernest J. Knabe

(a) RESIDENCE NO. Frederick Road & Athold ave St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Piano Mfg
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Ernest Knabe

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Laura Beck

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant E Kennedy Brown
(Address) 2 Germain Brown, Ohio

15 Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Monoxide Gas Poisoning

Undetermined (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Repairing Auto in Closed Garage (duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.
(Coroner)

Sept 28 1924 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 29 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Sons Co	Orchard & Fulton Ave

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90605

CERTIFICATE OF DEATH.

D 90605

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 217 N. Gilmor St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaretta Scheeler

(a) Residence No. 217 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1st, 1860

7-AGE,	If LESS than 1 day,
64 yrs. 4 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Henry Scheeler

11-BIRTHPLACE OF FATHER (city or town). Castle
(State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Saltzmann

13-BIRTHPLACE OF MOTHER (city or town). Castle
(State or Country). Germany

14- (Informant). Mrs. May Munder
(Address) 217 N. Gilmor Street

15- Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Sent.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 10, 1924, to Sept 26, 1924, that I last saw h.. alive on Sept 26, 19 24, and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis - dilatation of Heart - edema generale -

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs only

(Signed) Harry S. McCarty, M. D.

9-27-, 1924 (Address) 37 W. Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Sept 29, 19 24
20-UNDERTAKER. Joseph L. D. Cook	ADDRESS 1003 N. Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 90606 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3205 Guilford Ave St., 17 Ward) Registered No. 117

2-FULL NAME John. N. Beckley

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3205 Guilford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rose Beckley

6-DATE OF BIRTH (month, day and year) May 31 1872

7-AGE 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) American Molasses Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER. John N Beckley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER. Sophia Nagle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Rose Beckley

(Address) 3205 Guilford Ave

15- Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 25th 19 24 to Sept 26th 19 24

that I last saw him alive on Sept 26th 19 24

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) — yrs. — mos. Two ds.

CONTRIBUTORY (Secondary) General Peritonitis

(Duration) — yrs. — mos. One ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 25, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wilbur F Rieman M. D.

(Address) 6 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Pk

DATE OF BURIAL. 9-29 1924

20-UNDERTAKER. Mrs Chas A G Rohde

ADDRESS 600 N Arlington Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90607.

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. D 90607.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 N. Bradford ST., 8 WARD)

2-FULL NAME William Daugherty

(a) RESIDENCE No. 1601 N. Bradford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) March 10/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Joseph Daugherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md

12 MAIDEN NAME OF MOTHER Alice Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J.J. Daugherty (Father)
(Address) 1601 N. Bradford St

15 Filed ....192 ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar

SEP 29 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(History of Bronchitis several months previous) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Collins, M. D.
(Coroner.)

9/28/24. 192 (Address) 508 E. North Ave

*Write the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Sep. 29 192 4

20 UNDERTAKER E J Fanning & Son. 1938 E Lafayette Ave — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90608

CERTIFICATE OF DEATH.

D 90608

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 S Streeper ST., 8 WARD)

2-FULL NAME Frank Cwiek Jr.

(a) RESIDENCE NO. 1013 S. Streeper St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Sept 28 1924

7 AGE — Years | Months | Days | If LESS than 1 day, ½ hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ gas

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Frank Cwiek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Bertha Jaromin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Cwiek

(Address): 1013 S Streeper ✓

15 Filed SEP 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924, to Sept 28, 1924, that I last saw him alive on Sept 28, 1924, and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): 7 mths (premature)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 2124 Holland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sep. 29 1924

20 UNDERTAKER: John A. Weber — ADDRESS: 1803 Bank St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90609
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 90609
Registered No.

City of BALTIMORE: (No. 726 S. Potomac St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Caroline Schmaus

(a) Residence No. 726 S. Potomac St., 1 Ward
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 10 - 1919

7-AGE. 4 yrs. 9 mos. 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country). Md.

PARENTS

10-NAME OF FATHER. Henry E. Schmaus

11-BIRTHPLACE OF FATHER (city or town) Frostburg. (State or Country). N. J.

12-MAIDEN NAME OF MOTHER. Eva J. Feltzhaus

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country). Md.

14- (Informant) Henry E. Schmaus
(Address) 726 S. Potomac St.

15- Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 24th 1924 to Sept 26 1924

that I last saw her alive on Sept 25th 1924

and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod M. D.

, 19 (Address) 4704 Eastern ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sand Hill Cem. DATE OF BURIAL. Sept. 29 1924

20-UNDERTAKER. Lilly & Zeiler. ADDRESS 703 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90610

CERTIFICATE OF DEATH.

74-001

D 90610

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5510 Maple Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Euler

(a) RESIDENCE NO. 5510 Maple Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Euler

6 DATE OF BIRTH (month, day, and year) May 23, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George Euler

(Address) 5510 Maple Ave.

Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924, to Sept 27, 1924, that I last saw h[illegible] alive on Sept 27, 1924, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: 1 Paralysis Sequence Hemorrhage of Brain

(duration) 1 yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) High Blood Pressure (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. O'Donnell M. D.

Sept 29 1924 (Address) 3901 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Sept 29 1924

20 UNDERTAKER Wm. C. Black, ADDRESS 927 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90611

CERTIFICATE OF DEATH.

D 90611

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 Clifton ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Lammers

(Residence in Baltimore: No. 2842 Clifton ave St.; 55 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH. Feb. (Month) 2nd (Day) 1843 (Year)

7-AGE.	If LESS than 1 day,
81 yrs. 7 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Not any
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto. Md -

PARENTS.

10-NAME OF FATHER, Fred. Hoffman

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Mary C. Ruckark

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Robinson

(Address) 2842 Clifton Ave

15-

Filed SEP 28 1924 ROBERT N. KRAUTZ Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 27th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27th 1924, to Sept. 27th 1924, that I saw her alive on Sept. 27th 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer in arm pit started from a mole,

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Isaac E Dickson M. D.

Sept. 28, 1924 (Address) 3053 W. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	Sept. 30, 1924
20-UNDERTAKER H. Sander Sons	ADDRESS 1710 Mead St

Spec.—1-10-21—M&T—1500 Blks.

90612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓ D 90612

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 E Alisin ST., 4 WARD)

2-FULL NAME George P Regner

(a) RESIDENCE NO. 2314 E Alisin ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) HUSBAND of (or) WIFE of Leona Regner

6 DATE OF BIRTH (month, day, and year) Nov 1 1878

7 AGE: Years 46 | Months 7 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Inn Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Regner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Stingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo Regner Baltimore

Filed SEP 29 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-24 1924 to 9-27 1924 that I last saw h[illegible] alive on 9-27 1924 and that death occurred on the date stated above, at 9 1/4 A.M.

The CAUSE OF DEATH* was as follows:

Brain Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Sept 30 1924

20 UNDERTAKER: Geo E Miller & Son — ADDRESS: 2534 Huffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90613

CERTIFICATE OF DEATH.

D 90613

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ada Sweat

(a) Residence No. 1414 Hanford St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) [illegible]

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1897

7-AGE. 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). S. Carolina

PARENTS.

10-NAME OF FATHER, Nelson Herns

11-BIRTHPLACE OF FATHER (city or town) (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). S. Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- Filed SEP 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-26-24

17- I HEREBY CERTIFY, That I attended deceased from 9-21 1924 to 9-26 1924 that I last saw h[illegible] alive on 9-2[illegible] 1924 and that death occurred, on the date stated above, at .....m. The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis (?)

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Dorsey M. D.

9-27 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mayfield S C

DATE OF BURIAL. Sept 30 1924

20-UNDERTAKER. J. A. Brown & Son

ADDRESS 1018 W Monroe

Ball O R R (Expressed)

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90614

CERTIFICATE OF DEATH.

129 D 90614

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Mount St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Romeo Brooks.

3-RESIDENCE NO. 213 N. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Brooks

6 DATE OF BIRTH (month, day, and year) Feb. 22,1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer Wise

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Richard Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md.

12 MAIDEN NAME OF MOTHER Sophia Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant (Address) Mrs. Lucy Christphor (sister) 213 N. Mount St

15 Filed SEP 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st 24, to Sept. 25, 1924.

that I last saw him alive on Sept. 25, 1924

and that death occurred, on the date stated above, at 5;30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos. 25 ds.

CONTRIBUTORY (Secondary) Mitreal Ins.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? Physical Exam NO.

What test confirmed diagnosis? Urinaylis

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Sept 28, 1924

20 UNDERTAKER Mrs R A Elliott ADDRESS Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90615 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90615

CERTIFICATE OF DEATH.

1854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 243 McCulloh ST., 20 WARD)

REGISTERED NO. 1 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. Maurice Kern

(a) RESIDENCE NO 243 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Henry W. Kern

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Winerich

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Minnie Kern
(Address) 243 McCulloh St

Filed SEP 29 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Duffo Cation unknown
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Had Epileptic fit. Fell face downward in water
(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.
Sept 28, 192 (Coroner.)
(Address) Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether (Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon-Park DATE OF BURIAL Oct 1st 192 4

20 UNDERTAKER F. B. Wagaffe ADDRESS 1850 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90616 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90616

CERTIFICATE OF DEATH.

X 60 202

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. BALTO GEN'L HOSP'L. WARD 24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS. EDNA C. MORRIS.

(a) RESIDENCE No. 200 HOWARD AVE, LANSDOWNE MD. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
FEMALE	WHITE	MARRIED

5a If married, widowed, or divorced ~~DAUGHTER OF~~ ~~SON OF~~ ~~WIFE OF~~ wife GEORGE W. MORRIS

6 DATE OF BIRTH (month, day, and year) DEC. 20, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSE WIFE

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTIMORE MD.

PARENTS

10 NAME OF FATHER RIGBY HUBBARD

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTO. MD.

12 MAIDEN NAME OF MOTHER LENA L. LE COMPTE

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BALTO. MD.

14 Informant GEORGE W. MORRIS

(Address) 200 HOWARD AVE LANSDOWNE MD

Filed SEP 29 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1924, to Sept 28, 1924, that I last saw her alive on Sept 28, 1924 and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

COLLOID GOITRE

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) ACUTE MYOCARDITIS

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? YES Date of SEPT 25/24

Was there an autopsy? YES.

What test confirmed diagnosis? AUTOPSY - SIGNS & SYMPTOMS

(Signed) J. E. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK Sept 30 1924 DATE OF BURIAL

20 UNDERTAKER F. B. Wippert ADDRESS 1850 N. Balto St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

Dr. Lumpkin Tkse.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 90617.

D 90617

CERTIFICATE OF DEATH.

Carrollton Ave & Lafayette

88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 N. Longwood St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Hellmer

(a) RESIDENCE No. 1300 N. Longwood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herbert Hellmer

6 DATE OF BIRTH (month, day, and year): Jan 15. 1893

7 AGE: Years 31 | Months 8 | Days 12 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Bens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Herbert Hellmer

(Address): 1300 Longwood St

15 Filed SEP 28 1924, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27th 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1924, to Sept 27, 1924.

that I last saw h alive on Sept 27, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Infected Endocarditis.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lumpkin M. D.

Sept 27 1924 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Sept 30 1924

20 UNDERTAKER: F. B. Hepburt — ADDRESS: 2236 Fred'k Ave

(a) WRITE LEGIBLY, WITH UNFADING INK. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90618

CERTIFICATE OF DEATH.

REGISTERED NO. 314

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2249 Wilkens Ave ST., 20th WARD)

2-FULL NAME Mrs Ina Brown

(a) RESIDENCE No. 2249 Wilkens Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos R. Brown

6 DATE OF BIRTH (month, day, and year) Sept 22/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family
(c) Name of employer Chas. A. Scott 1886

9 BIRTHPLACE (city or town) (State or country) La.

PARENTS

10 NAME OF FATHER — Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) La

12 MAIDEN NAME OF MOTHER Mumford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant Mrs Barbara Green (Address) 2249 Wilkens Ave

15 Filed Sept 29 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos ds.

(Signed) Thos D Horton, M. D.

(Coroner) Sept 28 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 29 1924
20 UNDERTAKER F. B. Wisehart	ADDRESS 1850 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--1-12-23—M&T—500 Bks.

D 90619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90619

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3020 Arunah Ave ST., 16 WARD)

2-FULL NAME Ann T Burgess

(a) RESIDENCE NO. 3020 Arunah Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Mar.29,1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R.R. Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm T. Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Powers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Grace A Burgess

15 Filed SEP 29 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 24 Sept 27, 19 24 that I last saw h er alive on Sept 27,1924 19 , and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Pulmanary Tuberculosis

(duration) yrs. 6? mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas D. Kochlaus, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/30/24
20 UNDERTAKER	ADDRESS
Geo. A Farley	Fulton & Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

Roach

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90620

CERTIFICATE OF DEATH.

31

D 90620
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Roche

(a) Residence No. Farmers Hotel 600 Forest St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 8/20/1886

7-AGE. 38 yrs. 1 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gas Meter Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS.

10-NAME OF FATHER, John Roche

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eugenia Hart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Hospital Records

(Address) Md. T.H.

SEP 29 1924

ROBT. R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 23 1923 to Sept. 28 1924

that I last saw him alive on Sept. 28 1924

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Clin. & Path. findings

(Signed) J. F. Whites M. D.

Sept. 28. 1924 (Address) M. T. H.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Johns Cem. York Rd. & 30th	9/30/24 19

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Harford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 90621

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1706- Montpelier St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bridget Gault

(a) Residence No. 1706 Montpelier St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Richard Gault

6-DATE OF BIRTH (month, day and year) 4/15/1837

7-AGE. 87 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14-Informant John Gault

(Address) 1706 Montpelier

SEP 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March, 1924, to Sept 28, 1924

That I last saw h.. alive on Sept 27, 1924

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. J. Kinsey M. D

, 19 (Address) 700 Harford Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cath. Cem. DATE OF BURIAL, 9/30/24, 19....

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Harford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90622

12

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/59 D 90622

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn Kreidler

(a) RESIDENCE No. Bethlehem Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Harriett S Kreidler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Parent

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... ROBERT R. KRAUTH Registrar

SEP 29 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 23- 1924, to Sept 28- 1924, that I last saw her alive on Sept 28- 1924, and that death occurred, on the date stated above, at 10 15 p. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus - obstructive

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pa

Did an operation precede death? Yes Date of Sept 27-24

Was there an autopsy? Yes

What test confirmed diagnosis? Exam

(Signed) Warfield M Theobald M. D.

Sept 29, 19 24 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethlehem Pa — DATE OF BURIAL Sept 29 19 24

20 UNDERTAKER Joseph Stevens — ADDRESS 221 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90623

CERTIFICATE OF DEATH.

D 90623

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2516 McCulloh St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Bond

(a) Residence No. 2516 Mc Culloh St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. One mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black Negro

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of single

6-DATE OF BIRTH (month, day and year) Oct 22, 1878

7-AGE. 45 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 044

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Bel air Md.

PARENTS.

10-NAME OF FATHER. Wm E Bond

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bel air Md

12-MAIDEN NAME OF MOTHER. Harriet Hellen Worthington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Perryman Md

14- (Informant) Mrs E Bond

(Address) 2516 Mc Culloh St

SEP 29 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/27/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1924 to Sept 27 19 24

that I last saw h. ~~im~~ alive on Sept 27 19 24

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat with metastases in left Clavicle & neck

(Duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None known

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. exam.

(Signed) Chas. J. Keller, M. D.

, 19 (Address) 722 W Lombard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
Hendons Hill Cem	9/30/24
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Gamma av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 90624

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1008 W Baltimore St. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elva Farrell

(a) RESIDENCE NO. 1008 W Baltimore St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw Harrel

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mrs Elva Farrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edw Harrell

(Address) 1008 W Baltimore St

15 SEP 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1924, to Sept 27, 1924, that I last saw h[illegible] alive on Sept 27, 1924, and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis,

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Puerperal Sepsis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard N Fletcher, M. D.

9/29, 1924 (Address) 1725 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9/30/1924

20 UNDERTAKER David Earhart

ADDRESS 914 Pa Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90625 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 90625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 230 N. Duncan St., 6 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Berry

(a) Residence No. 230 N. Duncan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Max Berry

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 65? yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Bohemia

PARENTS.

10-NAME OF FATHER: Josef Petrik

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Bohemia

12-MAIDEN NAME OF MOTHER: Kate Krum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Bohemia

11-(Informant): John Berry

(Address): 230 N. Duncan St.

15-Robert P. Harrison,

19?? Registrar.

Burial Permit Clerk.

P 2 9-1924

Ed Mack

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 27/24

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to Sept 27 19 24

that I last saw h.. alive on Sept. 26 19 24

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(Duration) yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Horak M. D

19 (Address) 765 Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept. 30 1924

20-UNDERTAKER: Frank Erickson — ADDRESS: 1906 Eastern Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hospital

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., N. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H White

(a) RESIDENCE No. Oxford (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred yrs. Oxford, N.C. mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Tom White

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Kate Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Patient (Address) JOHNS HOPKINS HOSPITAL

15 SEP 29 1924

16 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Sept 29, 1924, that I last saw him alive on Sept 28, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(1) Acute Ascending meningo-myelitis. (2) Bilateral Pulmonary Tuberculosis. (3) Respiratory Failure

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Oxford N.C.

Did an operation precede death? Date of

Was there an autopsy? Complete

What test confirmed diagnosis?

(Signed) Thos Owen M. D.

Sept 29 1924 (Address) Johns Hopkins Hospital. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oxford N. C.	Sept 29 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90627

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Martin

(a) RESIDENCE No. 623 S Wolfe St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Martin

6 DATE OF BIRTH (month, day, and year) Unknown 1892

7 AGE: Years about 32 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. M Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa. Usa.

12 MAIDEN NAME OF MOTHER Louise Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa. Usa.

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed NOV 2 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to Sept 28, 1924, that I last saw her alive on Sept 28, 1924, and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (malignant

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Brain abscess

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? Yes Date of Aug. 9-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path.

(Signed) Warfield M. Firor, M. D.

(Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL Sept 30 1924

20 UNDERTAKER Wm. Cook ADDRESS 502 E. Fort Ave

NOTE.—WRITE PLAINLY, WITH UNFADING INK—EVERY question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90628

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-08

D 90628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hoffman

(a) Residence No. 2415 E Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1846

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison,

Filed ..... 192 Registrar.

Burial Permit Clerk

SEP 29 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-29-24

17- I HEREBY CERTIFY, That I attended deceased from 9-25, 1924, to 9-29, 1924, that I last saw him alive on 9-25, 1924, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gat

(Signed) Claude G. Drane M. D.

9-29, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Oct 1, 1924

20-UNDERTAKER. Whitcomb ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90629

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1846 N. Wolf St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Pierce

(a) Residence No. 1846 N. Wolf St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John W Pierce

6-DATE OF BIRTH (month, day and year) Apr 8-1861

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER Andrew J Weakley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER Margaret Fincham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Robt Pierce

(Address) 1846 N. Wolf St

15- Filed Sept 29 1924 Robert P. Harrison, Registrar.

Burial Permit Given

SEP 29 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 14th 1924 to Sept 28 1924

that I last saw her alive on Sept 28 1924

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Sclerosis &

Chronic Diffuse Nephritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Heart failure & Asthenia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) Wm D Dalbey, M. D.

9/29, 1924 (Address) 1625 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Orange Court House Va	Sept 30 1924
20-UNDERTAKER	ADDRESS
Robt J Turner Sons	N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90630

CERTIFICATE OF DEATH.

38

D 90630

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Byard

(a) Residence No. 1015 Chesapeake st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE,	If LESS than 1 day,
53 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John R. Byard

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Sept 29 1924 Robert P. Harrison, Registrar.

Asst Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 23, 19 23 to Sept. 27, 19 24, that I last saw h. im alive on Sept. 27, 19 24, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Syphilis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann, X-ray

(Signed) J. D. White, M. D.

9-27, 19 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Oak Lawn.	Sept 30th 1924
20-UNDERTAKER.	ADDRESS
Leo G. Cook	North & Harford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 9063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9063

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 N. Spring ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Walter

(a) RESIDENCE. No. 1639 N. Spring. ST., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, ~~or Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late August Walter

6 DATE OF BIRTH (month, day, and year): 2/2/1852

7 AGE: Years 72 | Months 7 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna Pathata

13 BIRTHPLACE OF MOTHER (city or town) (State or country): German

14 Informant: Mrs Mary Voshell (Address) 1639 N. Spring St.

15 Filed [illegible] 19 [illegible] Registrar

Burial Permit Clerk

2 9 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Sept 27, 1924, that I last saw her alive on Sept 26, 1924, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W Anderson M. D.

19 (Address) 1714 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 30 1924

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Hoffman Ave.

AGE should be carefully supplied. PHYSICIANS shou... that it may be properly classified. Exact statement o... tions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90632

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 90632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1322 W. Lexington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina Frederika Jaeger

(a) Residence No. 1322 W. Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Jaeger

6-DATE OF BIRTH (month, day and year) Jan 6 1856

7-AGE, 68 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Bentz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant. Rev John Jaeger

(Address) 1322 W. Lexington

15-Filed ..... 192.....

Robert P. Harrison, Registrar.

SEP 29 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 27 1924

17-I HEREBY CERTIFY, That I attended deceased from Sept 19th 19 24 to Sept 27 19 24

that I last saw h[illegible] alive on Sept 27 19 24

and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) Wm F. Jaeger M. D.

, 19 (Address) 1013 Poplar Grove St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem — DATE OF BURIAL, Sept 30 19 24

20-UNDERTAKER, Jos Joerdens & Son — ADDRESS 217 S. Roc

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

dr Coulton, 682 York Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90633

CERTIFICATE OF DEATH.

D 90633

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2501 W. Fayette St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison C White

(a) Residence No. 2501 W. Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-(If married, widowed, or divorced) HUSBAND of (or) WIFE Mary Ellen White

6-DATE OF BIRTH (month, day and year) Apr 7 1842

7-AGE. 82 yrs. 5 mos. 22 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER. H. H White

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary C Hoofnagle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Mary E White

(Address) 2501 W Fayette St

15-

Filed ..... 192.. (Signature of Registrar)

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 29 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1st, 1924 to September 29 24

that I last saw him alive on September 24 24

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of face

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J E Coulton M. D.

9/29/24 19 (Address) 3909 Gamon Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Lorraine	Oct 1, 1924
20-UNDERTAKER, Wm Cook	ADDRESS 5038 Park Ave

Burial Permit Clerk

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P 29 1924

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90634

D 90634

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Spillman, Geo. W.

(a) Residence No. 1269 Sargent St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, Married, Widowed, or Divorced, (Write the word.)
m.	W	M

5a-If married, widowed, or divorced, HUSBAND of ~~or WIFE~~ of Lillie Spillman

6-DATE OF BIRTH (month, day and year) 3/21/1886

7-AGE.	If LESS than 1 day,
38 yrs. 6 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer): Balto City

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS:

10-NAME OF FATHER, Geo. W. Spillman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Kate Norton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Lillie Spillman

(Address) 1269 Sargent St.

15- Filed SEP 25 1924, 192.. Robt. P. Warfield, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 29/924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Sept 29 1924

that I last saw h.. alive on Sept 28 1924

and that death occurred, on the date stated above, at 3 02 a.m.

The CAUSE OF DEATH* was as follows:

General paralysis of the Insane

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) 23 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes Clinical & Blood findings.

What test confirmed diagnosis?

(Signed) Claude C. Heiss M. D.

9-29 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Louden Park	Oct 1st 1924

20-UNDERTAKER,	ADDRESS
William Cook	502 E. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.- 1-10-21 M&T 1500 Bks.

D 90635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90635

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. High ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luigi Finni

(a) RESIDENCE NO. 403 S. High ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Sept 10 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Carlos. Finni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Pasquina Perpetua

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luigi Finni

(Address) 403 S. High St.

15 Robert P. Harrison, Registrar

P 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Septr 10, 1924, to Septr 29, 1924, that I last saw h.. alive on Septr 27, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematur Livers birth.

(Ground Scarcely.

(duration) ..... yrs. ..... mos 18 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D. M. D.

Sept 29 1924 (Address) 14 So Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Sept 30 1924

20 UNDERTAKER William Fiedforth ADDRESS 168 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question and information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90636

CERTIFICATE OF DEATH.

91-602 D. 90636

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Lombard St ST., 18 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J Walsh

(a) RESIDENCE No. 1207 Lombard St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Jennie Walsh

6 DATE OF BIRTH (month, day, and year) Aug 29, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Officer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Ferdinand Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) -

14 Informant Miss. N Walsh
(Address) 1207 Lombard St.

15 SEP 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 8 , 19 24 to Sept 26 , 19 24 ,
that I last saw him alive on Sept 26 , 19 24 ,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Kroelchen , M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Sept30 19 24

20 UNDERTAKER: Margaret G Flynn — ADDRESS: 1422 LightSt

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90637

CERTIFICATE OF DEATH.

177 D 90637

1-PLACE OF DEATH Church Home & Inf.

CITY OF BALTIMORE: (No. Broadway & Fairmount Av ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Metzelberger

(a) RESIDENCE NO. 741 South Third ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Lee Metzelberger

6 DATE OF BIRTH (month, day, and year) March 28. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George J. Metzelberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Virginia L. Metzelberger 1605 E. 33rd St

15 SEP 30 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 19 24, to Sept 28, 19 24, that I last saw him alive on Sept 28, 19 24, and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

(Primary) Infection of Lower Eyelid - Left

(duration) 1 yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 741 South Third St

Did an operation precede death? Date of 9/23/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John E. Norcum, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 1. 1924
20 UNDERTAKER Henry Sander & Sons	ADDRESS 1710 Fleet St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 924 Hamburger Court 23 St. ..... Ward) Registered No. 90

2-FULL NAME..... Isabell Height

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 924 Hamburger St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 1. 15. 92

7-AGE, 32 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... house work

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer..... Dead on 20

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Height

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, annie gross

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14-

(Informant) annie Height

(Address) 924 Hamburger Court

SEP 30 1924

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 27-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1924, to Sept 27, 1924, that I last saw ~~her~~ alive on Sept 20th, 1924, and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Intercranial Nephritis

(Duration) ..... yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular Disease of the Heart

(Duration) ..... yrs. 7 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ~~Autopsy~~ None

(Signed) E. Mc Kenzie, M. D.

, 19 (Address) 522 Hamburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Int auburn; DATE OF BURIAL, Sept 30 1924

20-UNDERTAKER, R L Parham; ADDRESS 902 Leadenhall St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90639 | D 90638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Lawson Smith

(a) RESIDENCE No. Route 10 Box 155 Sparrows point ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? X yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Smith

6 DATE OF BIRTH (month, day, and year): May 18/1902

7 AGE — Years: 22 — Months: 5 — Days: 7 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Fairfax, Va.

PARENTS

10 NAME OF FATHER: George Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westmoreland Co. Va.

12 MAIDEN NAME OF MOTHER: Mollie Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co. Va.

14 Informant: Mollie Boyd Lawson

(Address): Box 155 Sparrows Point

15 Filed SEP 30 1924 ROBERT N. KRAUTER Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Sept 25, 1924.

that I last saw h[illegible] alive on Sept 25, 1924,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis (post abortal puerperal)

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary): —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem Exam,

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bur[illegible] cemetery — DATE OF BURIAL: Sept 30, 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.*

N 111-607 D 90640

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. So BALTO GEN'L HOSP. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. WILLIAM FRANCIS REILLY

(a) Residence No. 3305 COLGATE AVE St. ..... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of KATHYRN REILLY

6-DATE OF BIRTH (month, day and year) MAY 4, 1883

7-AGE. 41 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... MERCHANT
(b) General nature of industry, business, or establishment in which employed (or employer)... SALOON
(c) Name of employer.....

9-BIRTHPLACE (city or town)..BALTO, MD
(State or Country),

PARENTS

10-NAME OF FATHER, PATRICK REILLY

11-BIRTHPLACE OF FATHER (city or town)..BALTO MD
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Anna Spriggs

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Baltimore

14-
(Informant) MRS KATHYRN REILLY
(Address) 3305 COLGATE AVE.

15-
Filed. SEP 30 1924 ROBERT R. KRAUTH Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) SEPT 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 19 24 to Sept 28 19 24
that I last saw h. alive on Sept 28 19 24
and that death occurred, on the date stated above, at. 7 30 A m.
The CAUSE OF DEATH* was as follows:
(RUPTURED) DUODENAL ULCER

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) GEN'L PERITONITIS

(Duration) ....yrs. ....mos. 5 ds.

18-Where was disease contracted if not at place of death? CITY JAIL

Did an operation precede death? YES Date of Sept 25/24

Was there an autopsy? YES

What test confirmed diagnosis? AUTOPSY & OPERATION

(Signed) J E Peterman M. D.

, 19 (Address) 1213 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn — DATE OF BURIAL. Oct 2 19 24

20-UNDERTAKER. John F Denny — ADDRESS. 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90641
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

23 57

D 90641
Registered No.

City of BALTIMORE: (No. 1327 Hanover St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry E Morgan

(a) Residence No. 1327 Hanover St., Ward
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 24/1895

7-AGE. 29 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer. B & O R.R.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. William T Morgan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Mathews Co Va

12-MAIDEN NAME OF MOTHER. Virginia R Posey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Somerset Co Md

14- (Informant) Virginia R Morgan

(Address) 1327 Hanover St

SEP 30 1924 ROBERT R. KRAUS Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 27/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 16/24, 19..., to Sept 27/24, 19..., that I last saw h[illegible]live on Sept 27/24, 19..., and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

H D Webb M. D.

(Address) 1210 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
London Park	Sept 30 1924
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D 90642

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John W. Howe

(a) RESIDENCE No. 2522 Ellamont St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 1859

7 AGE: 64 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of Industry, business, or establishment in which employed (or employer): 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: J. W. Howe

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Penna

12 MAIDEN NAME OF MOTHER: Ellen Bordeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Massachusetts

14 Informant: J. W. Howe

(Address): 2522 Ellamont Ave

15 SEP 30 1924 ROBERT R. KRAMER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to Sept 28, 1924, that I last saw him alive on Sept 28 1924 and that death occurred, on the date stated above, at 4 35 P m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Bilateral chronic Pyelonephritis

(duration) 3 years mos. ds.

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? Yes Date of Sept 25, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo C Worthington, M. D.

, 19 (Address) 1111 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 1 1924

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 90643

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 N. Monroe St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Girl Hardesty

(a) Residence No..... 819 N. Monroe St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
F	W	[illegible]

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 9/29/24

7-AGE.	If LESS than 1 day.
.....yrs.....mos. 16 hrs. ds.	15 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Harry Hardesty

11-BIRTHPLACE OF FATHER (city or town) Balt (State or Country),

12-MAIDEN NAME OF MOTHER, Mary E. Gerwig

13-BIRTHPLACE OF MOTHER (city or town) Balt (State or Country),

14- (Informant) Harry M. Hardesty

(Address) 819 N. Monroe St

15- SEP 30 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/29/24

17- I HEREBY CERTIFY, That I attended deceased from 9/28/24, 19....., to 9/29/24, 19....., that I last saw h... alive on 9/27/24, 19....., and that death occurred, on the date stated above, at 5 40 A.m. The CAUSE OF DEATH* was as follows:

Prematurity (two days)

Emp. Atelect.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) —

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Bernard Fenig, M. D.

1/30/ 19 25 (Address) 910 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cem	Sept 30, 1924
20-UNDERTAKER. George J. Smith	ADDRESS 1532 Hollins St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 90644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90644

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hosp. for Women of Md ST., 14 WARD)

2-FULL NAME Mrs. Thelma Bohannan Heidelbach

(a) RESIDENCE NO. ~~Hamilton~~ Hilton Ave Catonsville, Md ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Walter Heidelbach

6 DATE OF BIRTH (month, day, and year) Oct 16 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James H Bohannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J Walter Heidelbach

(Address) Catonsville

15 Filed SEP ... 19... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Sept 27, 1924, that I last saw her alive on Sept 27, 1924, and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

Child birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus. Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Kenneth B. Boyd. M. D.

, 19 (Address) Women's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 30 24
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	Hookstown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

For — 12-24 — 1000 Bks.

D 90645

Dietz

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90645

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S Paca St., ST., 22 WARD)

2-FULL NAME Charlotte Dietz

(a) RESIDENCE No. 603 S Paca St., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Getz

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Eistreiker

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant John C. Schuermund
(Address) 603 S Paca St.

Filed SEP 30 1924 ROBERT P. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

(Signed) ..... (Coroner.), M. D.

, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Oct 1st 1924
20 UNDERTAKER C Schuerman Son	ADDRESS 1534 Fleet St

NOTICE.—Information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90646 HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 90646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Costa (Costa) Constantine

(a) RESIDENCE NO. 2820 Gilford Ave, ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 30 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Costa Constantine (wife)

6 DATE OF BIRTH (month, day, and year) Sept-22-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62		0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant owner

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Self

9 BIRTHPLACE (city or town) ~~Greece~~ Tripoli
(State or country) Greece

PARENTS

10 NAME OF FATHER Costa Constantine

11 BIRTHPLACE OF FATHER (city or town) Tripoli
(State or country) Greece

12 MAIDEN NAME OF MOTHER Tula - (???)

13 BIRTHPLACE OF MOTHER (city or town) Tripoli
(State or country) Greece

14 Informant Mrs Kolet Olga Constantine (wife)
(Address) 2820 Guilford Ave

15 SEP 30 1924 ROBERT P. KNAPP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-25 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 4/1924, 19 , to Sept 25/24, 19 ,
that I last saw h alive on Sept 25/1924, 19 ,
and that death occurred, on the date stated above, at 1:15 p.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder.
(duration) yrs. 5 mos 0 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema & cardiac decompensation (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Cystoscopic

(Signed) E W Kroon, M. D.

. 19 (Address) Maryland Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Oct-1- 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 106 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

D 90647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3633 Liberty Heights St., 15 Ward)

Registered No. 1291

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albert Arnold

(a) Residence No. 3633 Liberty Heights St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. 5 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Arnold

6-DATE OF BIRTH (month, day and year) Apr. 6?-1860

7-AGE, 64 yrs. 5 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pres. of Co.

(b) General nature of industry, business, or establishment in which employed (or employer) W. E. Arnold Co.

(c) Name of employer (above.)

9-BIRTHPLACE (city or town) Alexandria (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm. Arnold

11-BIRTHPLACE OF FATHER (city or town) Alexandria (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Celia Field

13-BIRTHPLACE OF MOTHER (city or town) Alexandria (State or Country), Virginia

14- (Informant) Mrs. Mary R. Arnold (wife)

(Address) 3633 Liberty Heights Ave.

15- FILED SEP 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 28-24

17- I HEREBY CERTIFY, That I attended deceased from July 15 19.. to Sept 28 19.24 that I last saw h. alive on Sept 28 19.24 and that death occurred, on the date stated above, at 6.00 A.M. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

& Uremia

(Duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 9 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observed

(Signed) A. C. Lummis M. D.

(Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Sept 30 19.24

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90648

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes M. Fleischman

(a) Residence No. 1719 E Federal St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? fifty yrs. - mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 24 1909

7-AGE. 15 yrs. — mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Theodore A. Fleischman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Fannie L. French

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Mr. Theodore A. Fleischman

(Address) 1719 E. Federal St.

15- SEP 30 1924 BY ROBERT N. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 19 24 to Sept 28th 19 24

that I last saw h.er alive on Sept 28th 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis complicating appendicitis

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

18-Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Sept 24th

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Sybert M. D.

, 19 (Address) St Josephs Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy | DATE OF BURIAL, Oct 1st, 1924

20-UNDERTAKER Henry Hoch Son | ADDRESS 1301 E Eager St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

T. J. Nelson - Mary + Fulton,

D 90649

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 90649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 Pennsylvania Ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles A Coleman

(a) Residence No. 522 Pennsylvania Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 13 1924

7-AGE. ..... yrs. ..... mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Chas A Coleman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Pattie L. Whitehurst

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant). Mrs Pattie Coleman

(Address) 522 Pennsylvania Ave

SEP 30 1924 192 ROBERT N. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 13 1924 to Sept 29 1924 that I last saw h.. alive on Sept 12 1924 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Irreducible Cancer of Larynx

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ambrosia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. Nelson, M. D.

, 19 (Address) 1701 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Sept 30 1924

20-UNDERTAKER. Wm Carla — ADDRESS 502 E. Lt. Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56 D 90650

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Fulton ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse B Lewis

(a) RESIDENCE NO 702 Fulton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25

7 AGE — Years | Months: 7 | Days: 5 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jesse B Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Stella Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jesse B. Lewis
(Address) 702 Fulton St.

15 SEP 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hydrothorax

(Duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) yrs. mos. ds.

(Signed) J. Wm. Bloedorn, M. D.
(Coroner.)
Sept 29 1924 (Address) 1438 Bush

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem | DATE OF BURIAL: 9/30 1924

20 UNDERTAKER: Arnold Hensler (ADDRESS) 1218 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90651

CERTIFICATE OF DEATH. 1924

90651

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1821 Kensington St., 15 WARD)

2-FULL NAME Margaret Day

(a) RESIDENCE No. 1821 Kensington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June - 1921

7 AGE: Years 3 | Months 3 | Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ellie Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mathilda Wadlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ellie Day
(Address) 1821 Kensington St

15 Filed SEP 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) Geo. Edw. Schaal, M. D.
(Coroner.)

Sept 29 1924 (Address) 1426 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Sept 30 1924

20 UNDERTAKER: James L Beasley | ADDRESS: 1426 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90652

CERTIFICATE OF DEATH.

74-001

D 90652

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 Gough ST., 2 WARD)

2-FULL NAME Jacob Weiss

(a) RESIDENCE NO. 2007 Gough ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Weiss

6 DATE OF BIRTH (month, day, and year) Sept 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maragrit Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabth Weiss
(Address) 2007 Gough St

15 SEP 30 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 19 24, to Sept 27, 19 24.

that I last saw h alive on Sept 26, 19 24

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo Miller, M. D.

Sept 28, 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Sept 30 1924

20 UNDERTAKER John Ulbrich — ADDRESS 1018 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90653

CERTIFICATE OF DEATH.

16 1 801 ✓

D 90653

1-PLACE OF DEATH University Hosp.

CITY OF BALTIMORE: (No. Lombard & Green St., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 2144 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-27-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore / Md.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Smithfield, Va.

12 MAIDEN NAME OF MOTHER Alma Malbrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk, Va.

14 Informant Alma Smith

(Address) 2144 Division St

15 Filed 19

SEP 30 1924

ROBERT N. KRAMER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-27-, 1924, to 9-27, 1924, that I last saw him alive on 9-27, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Povey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 30 1924

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90654

90654

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 70 WARD)

2-FULL NAME Baby Thompson

(a) RESIDENCE NO. 2039 Stollers ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Illegitimate

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 2039 Stollers St

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant .....
(Address) .....

Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 24, to Sept 27, 19 24, that I last saw h.. alive on Sept 26, 19 24, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
6/12 mos interus

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas A Carter, M. D.

, 19 (Address) 2105 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 9/29/24

20 UNDERTAKER .....
per. Wm. E. Woodall

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

90655

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 90655

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md. 14 WARD)

2-FULL NAME Baby Zeul

(a) RESIDENCE No. 2270 Linden Ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 (Single) Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (Child)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Conrad Zeul

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Roberta A. Honiss

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland.

14 Informant .....
(Address) UNIVERSITY OF MARYLAND.

SEP 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1924, to Sept 28, 1924.

that I last saw h in alive on Sept 28, 1924,

and that death occurred, on the date stated above, at 9:25 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Arthur York, M. D.

(Address) Woman's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL SEP 30 1924

20 UNDERTAKER .....

ADDRESS .....

Per. Wm. E. WOODALL

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90655 — 100-001 — D 90656

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Hoffmann

(a) Residence No. Bay View Asylum St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cigr. Maker

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Louis Hoffman

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Md

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Md

11- (Informant) Municipal Hospital Records

(Address)

15- SEP 30 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-26-24

17- I HEREBY CERTIFY, That I attended deceased from 9-21, 1924 to 9-26, 1924

that I last saw him alive on 9-26, 1924

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude S. Dorsey M. D.

9-27, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

For Registrar of Health,

Reg. No. 1 W.C.H.A.L.

UNIVERSITY OF MARYLAND.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90657

CERTIFICATE OF DEATH.

90 D 90657

1-PLACE OF DEATH 115 Montebello Terrace

Registered No.....

City of BALTIMORE: (No. 115 Montebello Terrace St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaretha Kahlfleisch

(a) Residence No. 115 Montebello Terrace St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Kahlfleisch

6-DATE OF BIRTH (month, day and year) Apr. 19-1841

7-AGE, 83 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Jacob Wiegand

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Elizabeth Scheldt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Henry Dippelsman

(Address) 115 Montebello Terrace

SEP 30 1924

ROBERT P. KRAUTER

Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 27 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to Sept 27, 1924, that I last saw h.. alive on Sept 27, 1924, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. Simons, M. D.

Sept 27 1924 (Address) 706 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 30, 1924

20-UNDERTAKER, Harry H. Witzke — ADDRESS 1631 W. Lombard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90658 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90658

CERTIFICATE OF DEATH.

REGISTERED No. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Whitelock St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia N. Sonnenberg

(a) RESIDENCE. No. 809 Whitelock St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Sonnenberg

6 DATE OF BIRTH (month, day, and year) Dec. 9 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Simon Kurzhuyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Kearman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant H. Sonnenberg (Address) 809 Whitelock

15 SEP 30 1924 ROBERT S. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 28, 1924, that I last saw h[illegible] alive on Sept 28, 1924, and that death occurred, on the date stated above, at 11.03 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Miles Wheeler M. D.

Sept 29 1924 (Address) 2129 W Mt Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Jewish — DATE OF BURIAL: Oct 1 1924

20 UNDERTAKER: Hart Sondheim & Levy — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 90659

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Eutaw ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D Barnes

(a) RESIDENCE. No. 511 N Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced (or) WIFE of widow Wm. H. Barnes.

6 DATE OF BIRTH (month, day, and year) Mar. 26, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Daytonville, Maryland.

PARENTS

10 NAME OF FATHER Hanson Dugles.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Julia Stem.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Chas. H. W. Barnes. (Address) Manteno, Ill.

15 Filed ....., 19.... HUBERT R. KRAUTER Registrar

SEP 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30th 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 st, 1924, to Sept 30, 1924, that I last saw h.. alive on Sept 29, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. + mos. + ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of +

Was there an autopsy? no

What test confirmed diagnosis? Wasserman

(Signed) D Ken Williams M. D.

, 19 (Address) 601 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co., Md. Daytonville Cemetery

DATE OF BURIAL Oct. 2nd 1924

20 UNDERTAKER C. M. Watts.

ADDRESS Winfield Md

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

D 90660

CERTIFICATE OF DEATH.

D 90660

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albert Chaney

(a) Residence No. 3831 Hickory Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Chaney

6-DATE OF BIRTH (month, day and year) 9/29/80

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. conductor

(b) General nature of industry, business, or establishment in which employed (or employer). 078

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). " " "

12-MAIDEN NAME OF MOTHER. " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " " "

14- (Informant) Mrs May Chaney

(Address) 3831 Hickory Ave

15-

Filed SEP 30 1924 ROBERT B. ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/29/24.

17- I HEREBY CERTIFY, That I attended deceased from 9/24, 1924, to 9/29, 1924, that I last saw h[illegible] alive on 9/29, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Obstruction Bowel

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant tumor Kidney

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 9/27/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) L. Clarence Cohn, M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hampden — DATE OF BURIAL. Oct 2. 1924

20-UNDERTAKER. [illegible] — ADDRESS 904 N. Charles.

SHEPHOWETH & SON
3617 CHESTNUT AVE
Spring Garden Church

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9066I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9066I

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 22 Ward) 161-001

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Baby Girl Jackson

(a) Residence No..... 725 Broadway St.

(Usual place of abode) St., ... Ward .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Sept 17/24

7-AGE. .....yrs. .....mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Walter Allen

11-BIRTHPLACE OF FATHER (city or town) Richmond (State or Country), Va

12-MAIDEN NAME OF MOTHER, Florence Washington

13-BIRTHPLACE OF MOTHER (city or town) Harrisburg (State or Country), Pa

14-(Informant) Hosp. Records

(Address) JOHNS HOPKINS

15-SEP 30 1924 Robert P. [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 28-24

17-I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Sept 28, 1924, that I last saw h.. alive on Sept 28, 1924, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Jas J. Mara, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1924

20-UNDERTAKER.

ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-24—M&T—100 Blks.

D 90662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90662

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ----- Young

(a) RESIDENCE NO. 1404 Riggs Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of)))))

6 DATE OF BIRTH (month, day, and year) Sept 24/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15 hrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lula -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Johns Hopkins Hospital
(Address)

15 SEP 30 1924 192 Robert P. Harrison, Registrar
1823
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature], M. D.
(Coroner.)

9/26/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 30 1924 192

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90663

CERTIFICATE OF DEATH.

X 161-00 D 90663

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, WARD) 7

2-FULL NAME Phillip Kroll

(a) RESIDENCE No. ~~Holland & Phila Rd~~ Maynard Av ST., WARD Essex Balto Co

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xxxx

6 DATE OF BIRTH (month, day, and year) Sept 21/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15 hours			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Kroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Lillie -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Johns Hopkins Hospital
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 192 1821 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Allen (Coroner.), M. D.

9/25/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 30 192

20 UNDERTAKER ..... ADDRESS .....

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90664

CERTIFICATE OF DEATH.

1001 V

100 D 90664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. (If not in a hospital give WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Edwards.

(a) RESIDENCE NO. 701 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 55 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(h) General nature of industry, business, or establishment in which employed (or employer): Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mercy Hospital Record
(Address)

15 , 19 Robert P. Harrison,
Registrar

P 3 01924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/29/24

17 I HEREBY CERTIFY, That I attended deceased from 9/27/24, 19..., to 9/29/24, 19..., that I last saw him alive on 9/29/24, 19..., and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Decompensation
Arteriosclerosis Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) K. W. Kelley, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 1 19 24

20 UNDERTAKER: David Easton

ADDRESS: 916 Pennsa Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90666

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N. Schroeder St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Green

(a) Residence No. 227 N. Schroeder St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Green

6-DATE OF BIRTH (month, day and year) 1866

7-AGE.	If LESS than 1 day,
58 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Linen Ice Co.

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Peter Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Louis Green

(Address) 204 Druid Hill

15- Robert P. Harrison,

SEP 30 1924 192..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9/28/24

17- I HEREBY CERTIFY, That I attended deceased from 7/18/24 to 9/28/24

that I last saw h... alive on 9/28/24

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Probably Syphilitic Aort5

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Wind

(Signed) Kenneth Bowley M. D.

9/29, 19 24 (Address) 908 Sharp St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Laurel Cem	10/1/24
20-UNDERTAKER.	ADDRESS
Daniel Earhart	916 Penna. Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-Q.01

D 90667

D 90667 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N Robinson ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Chase

(a) RESIDENCE. No. 548 Scott ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29/24

7 AGE Years Months Days: 1 day

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 138 N Robinson St Baltimore Md

PARENTS

10 NAME OF FATHER Frank Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Father (Frank Chase)
(Address)

OCT 1 - 1924 RUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1924, to Sept 30, 1924, that I last saw h[illegible] alive on Sept 30, 1924, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) H B Kelly, M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Germ. Evangelical — DATE OF BURIAL: Oct. 1 1924

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D 90668

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Oak ST., 17 WARD)

2-FULL NAME Annie M. Henley

(a) RESIDENCE No. 2109 Oak ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa.

PARENTS

10 NAME OF FATHER Louis Henley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Rossner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs L R Jones
(Address) 2109 Oak St.

15 Filed OCT 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1924, to Sept 29, 1924, that I last saw h[illegible] alive on Sept 29, 1924 and that death occurred, on the date stated above, at 12, 20 PM

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ur Date of ...

Was there an autopsy? ur

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

9/29/1924 (Address) 2015 Hanford St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cem. DATE OF BURIAL Oct. 2 1924

20 UNDERTAKER Wm E. Black ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90669

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Hebrew Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Greenberg

(a) RESIDENCE NO. 1716 Warwick ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Shore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachel Bliefel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Dave Shore

(Address): 2012 Broadway

15 Filed OCT 1 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/29/1924

17 I HEREBY CERTIFY, That I attended deceased from 8/23, 1924, to 9/29, 1924

that I last saw h alive on 9/29, 1924

and that death occurred, on the date stated above, at 11:50 a m.

The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma

(duration) 2 yrs. 1 mos 0 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Stoller Landsmeer, M. D.

9/29/1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: Oct 1, 1924

20 UNDERTAKER: S. Levinson & Bro

ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24D 90670

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Arlington Ave ST. 19 WARD)

2-FULL NAME George Y. Peterman

(a) RESIDENCE No. 15 S. Arlington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Peterman

6 DATE OF BIRTH (month, day, and year): Aug 23-1845

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gunsmith

(b) General nature of industry, business, or establishment in which employed (or employer): ~~Gun~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Penna

PARENTS

10 NAME OF FATHER: Abraham Peterman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Penna

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Mr Dorsey S. Derr

(Address) 12 S. Arlington Ave

15 Filed ....., 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Sept 29, 1924,

that I last saw him alive on Sept 29, 1924,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

causing Left Hemiplegia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary): Senile Arteriosclerosis

(duration) over 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Tyler M. D.

(Address) 1203 W. Fayette St. Sept 30, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Oct 2 1924
20 UNDERTAKER: Wm J. Tucker Sons	ADDRESS: Norristown Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

90671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N-001

D 90671

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Wolfe ST., 7 WARD)

2-FULL NAME Ellen Washington

(a) RESIDENCE No. 1037 N Wolfe ST., ... WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? life time yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Jan 1 1874

7 AGE: 50. Years | 8 Months | 23 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Robinson

(Address) 1037 N. Wolfe St.

OCT 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Sept 28, 1924, that I last saw her alive on September 28 1924, and that death occurred, on the date stated above, at 5-10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

and Paralysis —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhag

(duration) yrs. mos. 2 days

18 Where was disease contracted if not at place of death? 1037 N Wolfe

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Thomas J Simms, M. D.

, 19 (Address) 1028 N. Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Oct 1 1924

20 UNDERTAKER: M. R. A. Elliott — ADDRESS: 1126 Eastland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 90672

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 210 Dorg alley St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hop. C Thong

(a) Residence No. 210 Dorg alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 58 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work. Merchant-

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), China

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) Billy Lew

(Address) 230 Park ave

15- Filed OCT 1 1924 ROBERT R. KRAUTER Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 29 1924

17- I HEREBY CERTIFY, That I attended deceased from September 20, 1924, to Sept. 29, 1924, that I last saw him alive on Sept. 28, 1924, and that death occurred, on the date stated above, at 1115 A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Zimmermann M. D.

, 19 (Address) 516 Cathedral St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Oct 2 1924

20-UNDERTAKER. John A Mitchell ADDRESS 201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90673

CERTIFICATE OF DEATH.

D 90673

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Edmondson ave ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Camilla Stephens

(a) RESIDENCE No 700 Edmondson ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	93	9	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A A Co Md

PARENTS

10 NAME OF FATHER Thos Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Martha Linthicum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant Geo E Dell
(Address) 402 W Lexington St

15 Filed OCT 1 1924 ROBERT A. KRAUS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. ... mos. ... ds.

(Signed) W K Peters M. D.
(Coroner.)

10-1 1924 (Address) 1170 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	10-1-1924
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Fayette sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90674

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 755 Dover St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Crumble

(a) Residence No. 755 Dover St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female | 4-COLOR OR RACE, Colored | 5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Crumble

6-DATE OF BIRTH (month, day and year) 1879

7-AGE, 45 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Stewart

11-BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Booth

13-BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or Country), Md.

14- (Informant) Gertrude Smallwood

(Address) 755 Dover St.

15- Filed ..... 192.... RUBEN R. KRAUSE
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27 1924 to Sept 30 1924

that I last saw h.r alive on Sept 30 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Yr

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Manley Strong, M. D.

Sept 30, 1924 (Address) 72 Wash. Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Oct. 2, 1924
20-UNDERTAKER,	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2139 Division ST. (14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Engelbert Morsell

(a) RESIDENCE. NO. 2139 Division ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Lawyer in New York

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Benjamin R Morsell

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Wallace

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Benjamin Morsell
(Address) 2139 Division St

15 Filed OCT 1 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 19 24, to Sept 28, 19 24, that I last saw h— alive on Sept 27, 19 24, and that death occurred, on the date stated above, at 10.45A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? No Date of

Was there an autopsy? No Why?

What test confirmed diagnosis? Bac. of Sputum

(Signed) W. H. Wright, M. D.

(Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 1 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Parsons

(a) RESIDENCE NO. Bacons Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Farm

(c) Nume of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Tony Parsons

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Bowles

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Records
(Address) Co. Court House

15 OCT 1 - 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Sept 27, 1924, that I last saw h alive on Sept 27, 1924, and that death occurred, on the date stated above, at 12 00 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) Urinary obstruction — prostate (duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Bacons Castle, Va.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Catheterization + rectal.

(Signed) W. W. Scott, M. D.

, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smith Field Va	Oct 1 1924
20 UNDERTAKER Edward Bryan	ADDRESS 631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90677 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hosp

CITY OF BALTIMORE: (No. Monument & Rutland ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bleza Brown

(a) RESIDENCE NO. 2208 Callow Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND n[illegible] tor) WIFE of Hirsh Brown

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, prnfesainn or particular kind of work Housewife

(b) General nature nf industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Baltimore St

15 Filed OCT 1 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1924, to Sept 30, 1924

that I last saw her alive on Sept 30, 1924

and that death occurred, on the date stated above, at 11:40 m.

The CAUSE OF DEATH* was as follows:

Cardiac failure
Starvation

(duration) 4 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Philip Jackson M. D.

, 19 (Address) Mercantile Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 10/1 1924

20 UNDERTAKER Jack Lewis 1439 E Baltimore St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90678

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 90678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Rayner avenue & Dukeland ST. 13 WARD)

2-FULL NAME Mr Max Berman.

(a) RESIDENCE NO. 2106 Callow ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Minnie Berman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	57	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Merchant. 245

(b) General nature of industry, business, or establishment in which employed (or employer) Office work chiefly.

(c) Name of employer

9 BIRTHPLACE (city or town) Nissan
(State or country) Russia.

PARENTS

10 NAME OF FATHER Mr Israel Berman.

11 BIRTHPLACE OF FATHER (city or town) Nissan
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Miss Minnie Goldman.

13 BIRTHPLACE OF MOTHER (city or town) Nissan
(State or country) Russia.

14 Informant Jack Louis
(Address) 1439 Eutaw ST

15 FILED OCT 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1924, to Sept 28, 1924, that I last saw him alive on Sept 28, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Syphilis -

Absent (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage sub Ter- minal Bronchopneumonia duration Cerebral Hemorrhage 20 days Bronchopneumonia 16 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Clement B. Manor, M. D.

, 19 (Address) West Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem

DATE OF BURIAL 10/1 1924

20 UNDERTAKER Jack Louis 1439

ADDRESS Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2833 Riggs Ave. St., 16 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Millard Baker,

(a) Residence No. 2833 Riggs Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE Annie E.Baker,

6-DATE OF BIRTH (month, day and year) July 14.1858

7-AGE,	If LESS than 1 day,
66 yrs. 2 mos. 17 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.Goverment

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, James M.Baker,

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Talbot CO.Md.

12-MAIDEN NAME OF MOTHER, Caroline Marshall.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Annie E.Baker, (Address) 2833 Riggs Ave

15- Filed ~~OCT 1~~ 1924 ROBERT R. KRAUTER, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) OCT 1 1924

17- I HEREBY CERTIFY, That I attended deceased from June, 1920 to Oct 1st, 1924, that I last saw h— alive on Oct 1st, 1924, and that death occurred, on the date stated above, at 6.15 A.m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Interis-Sclerotic

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) L. B. Culverhouse M. D.

10/1/1924 (Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL, Loraine — DATE OF BURIAL, OCT 3 1924

20-UNDERTAKER, Lee W. Little — ADDRESS 1708 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

(Borowick)

D 90680 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1612 Shakespeare St.; V Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Borowy

(a) RESIDENCE. No. 1612 Shakespeare St.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 30-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alexander Borowy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Szczepanowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Alexander Borowy

(Address) 1612 Shakespeare

Rec'd OCT 1 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1924, to Sept 30, 1924,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Atal Asis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Sayers, M. D.

Sept 30 24 (Address) 812 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL: Oct 1- 1924

20 UNDERTAKER: Jacob Paul, Towson

ADDRESS: 728 S. Bond St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90681

CERTIFICATE OF DEATH.

31 ✓ D 90681

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Ward 715 W Lanvale ST., 17 WARD)

2-FULL NAME Daniel Arnold Peck

(a) RESIDENCE NO. 715 Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Daniel C Peck

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hester Dull

13 BIRTHPLACE OF MOTHER (city or town) Worchester Co
(State or country) Md

14 Informant Nathaniel Peck (Brother)
(Address) 20 E Lanvale St

OCT 1 - 1924
ROBERT H. KRAUSER
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to Sept 29, 1924, that I last saw him alive on Sept 28, 1924, and that death occurred, on the date stated above, at 2:15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.
Unknown.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fibrous Pleurisy
Unknown.
(duration) yrs. mos. ds.

If Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical + Sputum

(Signed) R E Young M. D.

9/30 1924 (Address) 14 Eq & Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. M. Cleburne Lawn — DATE OF BURIAL Oct 1 1924

20 UNDERTAKER Samuel H. Hawley — ADDRESS W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Elizabeth Lois Reese.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90682

CERTIFICATE OF DEATH.

D 90682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2-FULL NAME Miss Betty Reese (Elizabeth Lois).

(a) RESIDENCE NO. Westminster Maryland. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of daughter of Mr. John Reese.

6 DATE OF BIRTH (month, day, and year) Sept 8/1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. (Kinder garden)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Carroll Co. Maryland.

PARENTS

10 NAME OF FATHER Mr. John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mary Gullett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salisbury Md

14 Informant Father- Mr. John Reese

(Address) Westminster Md

15 OCT 1 - 1924

ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Sept 29, 1924, that I last saw her alive on Sept 29, 1924, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

1. Acute Cholecystitis
2. Acute Appendicitis.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Acute Ileus

(duration) yrs. mos. 24 hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 26-1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. W. Keene, M. D.

, 19 (Address) Maryland General Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL Oct 2 1924

20 UNDERTAKER W M Routson

ADDRESS 2238 N Mth

Spec– 12-23-21– E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90683

CERTIFICATE OF DEATH.

1924 D 90683

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 52 11 Dennison Ave ; St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Mason

(a) Residence No. 52 11 Dennison Ave St., Ward

(Usual place of abode)

Rhode Island

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Augustus B Mason

6-DATE OF BIRTH (month, day and year) April 1861

7-AGE. 62 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) New Port R Island

PARENTS.

10-NAME OF FATHER Pascal Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Va

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Rhode Island

14- (Informant) Mary E Craig.

(Address) 52 11 Dennison Ave

15- OCT 1 - 1924

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 30/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 19 24 to Sept 30 19 24

that I last saw h.. alive on Sept 30/24 19.....

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? New Port R Island

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D

9/30/24 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville

DATE OF BURIAL Oct 3 1924, 19...

20-UNDERTAKER. Emmart & Dwyer

ADDRESS 1264 W Cary

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90684

CERTIFICATE OF DEATH.

9 D 90684

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 W. 36th St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LeRoy Linton Burns

(Residence in Baltimore: No. 865 West 36th St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, Oct. (Month) 27 (Day), 1923 (Year)

7-AGE, ...yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City Md

PARENTS.

10-NAME OF FATHER, LeRoy L Burns

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md

12-MAIDEN NAME OF MOTHER, Mary B. Tracey

13-BIRTHPLACE OF MOTHER (State or Country), Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. In. L Burns

(Address) 3447 Elm Ave

15-

Filed OCT 1 - 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September 30 (Month) (Day), 1924 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 4 1924, to Sept. 30 1924, that I saw him alive on Sept 30 1924, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ....yrs. ....mos. 26 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs. ....mos. 8 ds.

(Signed) C. O. Wantz M. D.

Sept 30, 1924 (Address) 865 W. 36th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hanbts

DATE OF BURIAL, Oct 1, 1924

20-UNDERTAKER CHENOWETH & SON

ADDRESS 3917 CHESTNUT AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90685

CERTIFICATE OF DEATH.

117

D 90685

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2832 Bernard St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frederick Smith

(a) RESIDENCE, No. 2832 Bernard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 11 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17. 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Frederick Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lina Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Haven Md

14 Informant Thomas Smith

(Address) 2832 Bernard St

15 Filed ....., 19 .... Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Sept 30, 1924, that I last saw h.. alive on Sept. 29, 1924, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Exhaustion due to

Acute Leuc (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Dorsey, M. D.

, 19 (Address) 2101 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 2 1924

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 90686

D 90686

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Arlington Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Mary Lyons

(Residence in Baltimore: No. 915 Arlington Ave St.; 21 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) ..... (Day), 1872 (Year)

7-AGE, 52 yrs. 4 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 10 01

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Tim Butler

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Bertie Butler

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Washington

(Address) 915 Arlington Ave

15-

Filed ..... 191.....

Robert T. Harrison, Registrar.

T1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5th 1924, to Sept 30 1924, that I saw h.. alive on Sept 30th 1924, and that death occurred, on the date stated above, at 12:50 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) High Blood Pressure

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Jas C Carson M. D.

10-1-1924 (Address) 1063 N Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodstock Md

DATE OF BURIAL, Oct 2, 1924

20-UNDERTAKER Sam'l H Chase & Son

ADDRESS 1401 Mosher

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. St Agnes Hospital St., 4185 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hagan

(a) Residence No. 416 N. Saratoga St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Edward Hagan. ~~Do not know~~

11-BIRTHPLACE OF FATHER (city or town) Do not Know (State or Country) " "

12-MAIDEN NAME OF MOTHER, Ann Hagan " "

13-BIRTHPLACE OF MOTHER (city or town) Do not Know (State or Country) " "

14- (Informant) Agnes J Barrett (Address) 416 N. Saratoga St

15- Filed ....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-30-24

17- I HEREBY CERTIFY, That I attended deceased from 9-6- 1924 to 9-30 1924

that I last saw h[illegible] alive on 9-30 1924

and that death occurred, on the date stated above, at 6 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Jawbone

Chronic Myocarditis & Senility

(Duration) 10 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Fracture left femur

Pulmonary Edema (Duration) yrs. 1½ mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. F. Kenna M. D.

, 19 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL. Oct 2' 1924

20-UNDERTAKER Wm J Hartwell & Co ADDRESS 2236 Baltimore St

T1 - 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

D 90688

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 17 WARD)

2-FULL NAME Thomas B. Webster

(a) RESIDENCE No. 3036 St. Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Manager Oyster business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Silas Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. Preston Webster

(Address) 3036 St. Paul st

15 OCT 1 - 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1924, to October 1, 1924,

that I last saw him alive on Oct 1, 1924,

and that death occurred, on the date stated above, at 3 05 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? Yes Date of Jan 5, 1924

Was there an autopsy? No

What test confirmed diagnosis? Section of tissue removed at operation

(Signed) Donald C. Gandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dead Island Md — DATE OF BURIAL Oct 2nd 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90689 ✓ D 90689

CERTIFICATE OF DEATH.

159-003

REGISTERED NO. 3

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Exeter ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Horowitz (or Hanover)

(a) RESIDENCE No. 120 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 13 1914

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Louis Horowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Horowitz (Address) 120 S. Exeter st

15 Filed ..... 192 ..... Registrar

11-1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. ds.

(Signed) James McKenlon, M. D. (Coroner.)

Oct 1 1924 (Address) 700 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilson M Lawn	10/1 1924
20 UNDERTAKER	ADDRESS
Sol Levinson & Bro	1127 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec--12-23-21--E.B.R.S.--400 Eks.

D 90690 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 44

City of BALTIMORE: (No. 3723 E. Pratt St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Gustave Keller

(a) Residence No. 3723 E. Pratt St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmidt

6-DATE OF BIRTH (month, day and year) Dec 12-1857

7-AGE. 67 yrs. 9 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Baker
(b) General nature of Industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.
10-NAME OF FATHER, Jacob Keller
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Lost Knor
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Miss Dora Keller
(Address) 3723 E. Pratt St

15- Filed OCT 1 1924, 192. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/29/1924

17- I HEREBY CERTIFY, That I attended deceased from 8-31-24 to 9-29-24
that I last saw h. alive on 9-19-24
and that death occurred, on the date stated above, at 7:15 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis Liver

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) † Frederick W. Hermann M.D.
10-1-24 (Address) 7913 Belto Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem	Oct 2 1924
20-UNDERTAKER.	ADDRESS.
Jno Ulrich	2008 Aliceanna

ROBERT P. HARRISON, Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK. DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9069 1

89 D 9069 1

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1520 E. Biddle St. 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas J. Price

(Residence in Baltimore: No. 1520 E. Biddle St.; 76 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED,~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widower.

6 DATE OF BIRTH: Oct 12, 1805 (Month) (Day) (Year)

7 AGE: 73 yrs. 11 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Hardware business

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frederick Price

11 BIRTHPLACE OF FATHER (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw Price

(Address) 1520 E Biddle St

15 Robert P. Harrison,

Filed ..... 191 ..... Deputy Health Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 29 (Month) (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924 to Sept. 29, 1924 that I saw h[illegible] alive on Sept. 29, 1924 and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Gangrene of Lower extremities
Shock

(Duration) ..... yrs. 3 mos. ..... ds

Contributory (SECONDARY) Carbon Monoxide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno H Hartman M. D.

Oct. 1, 1924 (Address) 2211 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge — DATE OF BURIAL: Oct 2, 1924

20 UNDERTAKER: John Lecard — ADDRESS: 208 Chelsea

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90692 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Joseph's Hosp St., No Ward)

Registered No. 155

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Juliano

(a) Residence No. 3902 Clairmount Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 29/1908

7-AGE, 16 yrs. 3 mos. 2 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Juliano

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Fannie Bokone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) James Juliano

(Address) 3902 Clairmount Ave

15-

Filed 192

Registrar.

CT 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 1-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1924 to Oct. 1 1924

that I last saw him alive on Oct. 1 1924

and that death occurred, on the date stated above, at 3 32 Am.

The CAUSE OF DEATH* was as follows:

Acute myeloid Septicemia

(Duration) yrs. 1 wk mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Sept 25/24

Was there an autopsy? No

What test confirmed diagnosis? Clin. Lab. Test

(Signed) Geo. B. Dyer M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Louis Cem. DATE OF BURIAL. Oct 3 1924

20-UNDERTAKER. John Ellrich ADDRESS 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A.

DAK

Spec.—1-10-21—M&T—1500 Bks.

D 90693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 90693

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Bradford ST., 1 WARD)

2-FULL NAME Louis. Anuszewski

(a) RESIDENCE NO. 504 S. Bradford ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis. Anuszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Teresa. Szczepaniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Teresa. Anuszewski
(Address) 504. S. Bradford Street

15 Filed 1924 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 19 24

17

I HEREBY CERTIFY, That I attended deceased from 7/24, 1924, to 9/30, 1924.

that I last saw h[illegible] alive on 7/28, 1924

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Cyanosis entirely [illegible]
collapse

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure & exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay D Ondegg, M. D.

19 (Address) 1623 E Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem.	Oct. 1 1924
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. Joseph Sarzynski ✓

D 90694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 101-001

D 90694

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., V WARD)

2-FULL NAME Joseph Sarzynski

(a) RESIDENCE NO. 520 E Alto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 14 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Sarzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ann Post

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Record
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 1 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Sept 30, 1924, that I last saw h... alive on Sept 27, 1924, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) myocardial failure

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pneumo.

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Oct, 3 1924

20 UNDERTAKER John McWeber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 90695

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Broadway & Fairmount ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Thomas K. Worthington

(a) RESIDENCE NO. 4017 Roland Ave. City ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~XXXXXX~~ Mary G. Worthington

6 DATE OF BIRTH (month, day, and year) Apl. 23, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Md. Casualty Co.

9 BIRTHPLACE (city or town) Germantown
(State or country) Pa.

PARENTS

10 NAME OF FATHER Joshua Worthington

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Harold Worthington
(Address) 27 William St. New York, N.Y.

15 - 1924 Robert P. Harrison, ... 19 .....
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 30. 1924 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 15-24, 19 24, to Sept 30-24, 19 24,

that I last saw him alive on Sept 30-24, 19 24,

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Hypertension, Myocarditis, Arteriosclerosis

Pyelitis; pleural effusion.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) George B Brief, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa	Oct 2-24 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T1

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90696

CERTIFICATE OF DEATH.

142

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 Wordburne Ave. St., 7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Clark

(a) Residence No. 726 Wordburne Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. W. Clark

6-DATE OF BIRTH (month, day and year) April 16, 1861

7-AGE. 63 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. nr. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS:

10-NAME OF FATHER, Valentine Batzer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Julianna Becker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) George W. Clark

(Address) 726 Wordburne Ave.

15-

Filed OCT 1 - 1924 12- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 29 - 24

17- I HEREBY CERTIFY, That I attended deceased from July 3 1924 to Sept 29, 1924

That I last saw her alive on Sept 28 1924

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Paget's Disease (Arthritis Deformans)

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) 1. Pneumonia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Clinical findings

(Signed) D. K. Bush M. D.

Oct 1, 1924 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Oct. 2 1924
20-UNDERTAKER	**ADDRESS**
William G. Schaffer	1816 Monument

I certify that the above is a true copy of the original certificate filed in the Health Department of Baltimore City.

Robert P. Harrison, Registrar.

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90697

CERTIFICATE OF DEATH. 188-101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute to Mercy Hospital. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Joseph Stewart.

(a) RESIDENCE NO. Violet Ave. English Consul. ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Emma Stewart.

6 DATE OF BIRTH (month, day, and year) May, 10, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer Locke Insulator Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George J. Stewart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Riley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant James Stewart, (son)
(Address) 1835 Light St.

15 Filed ..... 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CT 1 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal hemorrhage, Rupture of Liver
Accidentally struck by B. & O. train
while riding in an automobile reck-
lessly driven onto R. R. tracks.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)
Oct. 1, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Russell & Ostend st. crossing of B. & O. R. R.

Former or usual residence September, 29, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Oct. 2 1924

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light St.

...mation should be carefully supplied. ...CAUSE OF DEATH in plain terms, so that ...TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90698

CERTIFICATE OF DEATH.

X36-004

D 90698

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Mercy Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Lorringer

(a) RESIDENCE NO. Church Lane Pikesville Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche Lorringer

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 42 Months 7 Days 2 If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate Agt

(c) Name of employer: Ind. 026

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Lorringer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lorringer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant (Address): Hospital Record.

15 Filed OCT 2 - 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/29/24

17 I HEREBY CERTIFY, That I attended deceased from 9/22/24 19.., to 9/29/24 19..

that I last saw him alive on 9/28/24 19..

and that death occurred, on the date stated above, at 4:20 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Y Stock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 9/28/24

Was there an autopsy? no Blood & Urine

What test confirmed diagnosis?

(Signed) K. W. Hartley, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Oct. 2 1924

20 UNDERTAKER: Martin Feahey & Son — ADDRESS: 1727 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Stokes

HEALTH DEPARTMENT—CITY OF BALTIMORE

90699

CERTIFICATE OF DEATH.

113 D 90699

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Tyson ST., 11 WARD)

2-FULL NAME Geraldine Stokes

(a) RESIDENCE NO. 510 N Tyson ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Mary Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Catherine Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Catherine Stokes (Address) 510 Tyson

15 Filed OCT 2 - 1924 ROBERT A. KRAITER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1 1924

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1924, to Oct 1st, 1924, that I last saw him alive on Sept 30, 1924, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum (duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary) Totality (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Lohman, M. D.

, 19 (Address) 15 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Oct 2 1924
20 UNDERTAKER Mrs B A Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90700

CERTIFICATE OF DEATH.

44

D 90700

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Barnes ST., 7 WARD)

2-FULL NAME Anna Collins

(a) RESIDENCE NO. 1715 Barnes ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Black a. a

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Thomas

6 DATE OF BIRTH (month, day, and year): Feb. 24 1855

7 AGE: Years 69 (~~75~~) Months 8 Days 5 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Sallie Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Jane P. Cornish

(Address) 1715 Barnes St

15 Filed OCT 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to Sept. 29, 1924, that I last saw her alive on Sept. 29, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary): Acute nephritis

(duration) ... yrs. ... mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

(Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL Oct 1924

20 UNDERTAKER: Wm. R. Gilbert — ADDRESS 1726 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001

D 90701

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1610 Thames ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustaf Mattson

(a) RESIDENCE No. 1610 Thames ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 17/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipcarpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Principal 015

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Matthias Mattson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Ernest Mattson
(Address) 1610 Eastern Ave New York City

15 OCT 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by Illuminating Gas probably Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James W Fenlon, M. D.
(Coroner.)

Oct 1, 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1610 Thames Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 2 1924

20 UNDERTAKER Wm. Cook — ADDRESS 502 E Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D 90702

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer T. Turner

(a) Residence No. 1014 N. Dallas St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 8 1875

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Painter

(b) General nature of Industry, business, or establishment in which employed (or employer). O.S.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Maryland (State or Country).

PARENTS

10-NAME OF FATHER, J. H. Turner

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country).

12-MAIDEN NAME OF MOTHER, Hannah Silver

13-BIRTHPLACE OF MOTHER (city or town) W. Va (State or Country).

14- (Informant) Municipal Hospital Records

(Address).....

OCT 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-1-24

17- I HEREBY CERTIFY, That I attended deceased from 8-21, 1924 to 10-1, 1924 that I last saw h. alive on 9-30, 1924 and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(Duration) 1 yrs. (History) mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Wood M. D.

10-1-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Oct 4, 1924
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Nor Ave

A72

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90703

Joseph V. Schimmel

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 - X 49

D 90703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Garrison Blvd ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph V Schimmel

(a) RESIDENCE NO. 3101 Garrison Blvd ST., WARD New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19, 1888

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer 045

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Fibre

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baden. Austria, Europe

PARENTS

10 NAME OF FATHER Ossen Schimmel

11 BIRTHPLACE OF FATHER (city or town) Dubrecin (State or country) Austria Europe

12 MAIDEN NAME OF MOTHER Zelle Zuckerbier

13 BIRTHPLACE OF MOTHER (city or town) Dubrecin (State or country) Austria Europe

14 Informant Harry Schimmel

(Address) 75 Bowley Ave Bronx

15 Filed OCT 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 19 24

17

I HEREBY CERTIFY, That I attended deceased from Mar. 19 24, to Oct 1, 19 24.

that I last saw him alive on Oct 1, 19 24,

and that death occurred, on the date stated above, at 9. 40 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

or

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? yes Date of Mar. 15, 1924

Was there an autopsy? no

What test confirmed diagnosis? Exploration

(Signed) M. V. Schimmel, M. D.

. 19 (Address) 3101 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cemetery	Oct 3/ 1924
20 UNDERTAKER J. Cohen & Co	ADDRESS 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90704

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George Boeckel

(a) RESIDENCE No. 1806 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: MALE

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer): Employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Charles F. Boeckel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Rightmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. George Boeckel

(Address): 1806 W. Lexington St.

15 Filed OCT 2 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1924, to Sept. 30th, 1924, that I last saw him alive on Sept. 30th, 1924, and that death occurred, on the date stated above, at 7:05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Colitis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-24-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. W. Tompkins, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 3rd 19 24

UNDERTAKER: F. B. Nesbitt

ADDRESS: 1850 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

D 90705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 ✓

D 90705

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Collington Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Glaser

(a) RESIDENCE No. 209 N. Collington Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Michael Glaser

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lobixs Lowenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rose Levy (Sister-in-law)
(Address) 830 Chauncey Ave

OCT 2 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Pulmonary Hemorrhage

Shock -Fright (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

(Signed) J. H. Koelln, M. D.

10/1/24 192 (Address) 5pr E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Hebrew Cemetery — DATE OF BURIAL Oct 3/192 4

20 UNDERTAKER J. Chas. Stein & Co. — ADDRESS 16 11 Mulberry

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90706

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 2306 E. Chase St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Habkemeier

(a) Residence No. 2306 E. Chase St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Fred Habkemeier

6-DATE OF BIRTH (month, day and year): Nov. 27-1865

7-AGE: 58 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Ameil Marcks

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Lotta Habkemeier

(Address): 2306 E. Chase St.

15- OCT 2 - 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 27-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 19.. to Oct 29 19 24

that I last saw ... alive on Oct 29 19 24

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes

Pleurisy & Pneumonia

(Duration) 3d mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lung

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) M Mazoby M.D.

Oct 29 1924 (Address) 800 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

DATE OF BURIAL: Oct 2, 1924

20-UNDERTAKER: John H Brown

ADDRESS: 3000 E. Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90707. **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 D 90707.

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Penn Ave ST., 16 WARD)

2-Hanover Trial Prison.

(a) RESIDENCE NO. 938 Stricker St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) Taki
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Unknown

14
Informant Minnie Lewis
(Address) 526 Lombard St

OCT 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Duration Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) Geo Clinton Hobbs, M. D.
(Coroner)

192 (Address) 1736 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10/1/24
20 UNDERTAKER	ADDRESS
Dan'l Easton	916 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90708

CERTIFICATE OF DEATH.

1-001

D 90708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Seifert

(a) RESIDENCE NO. 324 Ringgold ST. (Ringgold St) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 20 1912

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
12	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Bunck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Hospital Record

(Address)

15 OCT 2 - 1924

ROBERT N. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/30/24

17

I HEREBY CERTIFY, That I attended deceased from 9/16/24, 19..., to 9/30/24, 19...

that I last saw h~~e~~ alive on 9/30/24, 19...

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Epidural Abscess

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Perforated Intestine

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ? Laboratory

Did an operation precede death? Yes Date of 9/30/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gilley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cmetery

DATE OF BURIAL: Oct 4 1924

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90709

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. D 90709

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 S Gilmor ST., 19 WARD)

2-FULL NAME George H Plateau

(a) RESIDENCE NO. 339 S Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucie M. Plateau

6 DATE OF BIRTH (month, day, and year) Jan 8, 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaint

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Jno F Whitman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lucie M Plateau

(Address) 339 S Gilmor

Filed OCT 2 - 1924

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to Sept 30, 1924, that I last saw him alive on Sept 29, 1924, and that death occurred, on the date stated above, at 7.5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Myocarditis

(Signed) James H Fitzgerald M. D.

9/29, 1924 (Address) 1724 N Dukeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 3 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

Dr Herman 2913 C Balt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90710

D 90710

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 South 3rd St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B Stanley

(a) Residence No. 14 South 3rd Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Carrie T Stanley

6-DATE OF BIRTH (month, day and year) March 7. 1866

7-AGE. 58 yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer Balto Md

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER Buchanan Stanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Thompson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md.

14- (Informant) Carrie Stanley

(Address) 14 S 3rd St

OCT 2 - 1924

ROBERT A. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from 7-6-1924 to Oct 1-1924

that I last saw him alive on Sept 9-1924

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Amotrophic Lateral Selerosis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) nour

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick H Herrman

10-1-1924 (Address) 2913 C Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Oct 4, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 532 E Lath Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 90711

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1402 Yeager St St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Trout

(a) Residence No. 1402 Yeager St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Emma H

6-DATE OF BIRTH (month, day and year) April 1-1840

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Frederick Md

PARENTS

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-INFORMANT. Geo. C. Trout

(Address) 1402 Yeager

15-FILED OCT 2 - 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/1/24

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to Oct-1 1924

that I last saw h... alive on Oct. 1 1924

and that death occurred, on the date stated above, at 2.15 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure

(Duration) 3 yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. Hampden M. D.

Oct 1 1924 (Address) 3701 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Oct. 3, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 512 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1854 D 90712

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N. Carrollton Av. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Hammond

(a) Residence No. Curtis Bay Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 Wks yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Lillian M Cromwell

6-DATE OF BIRTH (month, day and year) Sept 3 1867

7-AGE. 57 yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), A.A. Co Md

PARENTS.

10-NAME OF FATHER, John T Cromwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), AA Co Md

12-MAIDEN NAME OF MOTHER, Ramsadel Shipley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) AA Co Md

14- (Informant) Lillian May Hammond

(Address) Curtis Bay Md

15- ROBERT R. KRAUTER,

OCT 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 14, 1924 to Sept 30, 1924

that I last saw h.. alive on Sept 30 1924

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Fractured 3rd Cervical Vertebrae.

(Duration) yrs. mos. 47 ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. 30 ds.

18-Where was disease contracted if not at place of death? Curtis Bay

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Coroner Murray M. D.

, 19 (Address) 1221 W. Lafayette Ave,

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	Oct 2, 1924
20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

1221 W Lafayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 90713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90713

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 N. Eutaw St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Garlin

(a) Residence No. 419 S. Durham St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Barrie Garlin.

6-DATE OF BIRTH (month, day and year) April 2nd 1864

7-AGE. 60 yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mariner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George Garlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Bridget O. Donnell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-(Informant) Fritz patrick Garlin

(Address) 129 N. Eutaw St.

15-Filed OCT 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1924 to Sept 29 1924 that I last saw him alive on Sept 29 1924 and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Ch Parenchymatous Nephritis

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. L. Hamilton M. D

9/31 1924 (Address) 733 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cemetery

DATE OF BURIAL. Oct 3rd 1924

20-UNDERTAKER. Lilly & Zieler

ADDRESS 4032 Reisterstown Rd

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90714

CERTIFICATE OF DEATH.

181-007 D 90714

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Orleans St ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold J. Cook

(a) RESIDENCE No. 1932 Orleans St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) July 24/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jesse Wm. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Eva Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant: Jesse Wm. Cook
(Address) 1932 Orleans St

15 Filed OCT 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Suffocation while asleep in its crib.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Cullen, M. D.
(Coroner.)

9 Oct 1/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: Oct. 2nd 1924

20 UNDERTAKER: Philip Stenig

ADDRESS 2016 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90715

CERTIFICATE OF DEATH.

50 D 90715

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Herrman Ct. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Jackson

(a) RESIDENCE No 820 Herman Ct ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant .....
(Address) .....

15 Filed OCT 2 1924 ROBERT RESNICK, Registrar
Burial Permit Clerk

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficien cy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prob. Fibrosis of Coronary arteries

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cullen, M. D.
(Coroner.)

9/30/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL OCT 2 192 4

20 UNDERTAKER .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90716

CERTIFICATE OF DEATH.

001 ✓ 101 D 90716

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 22 WARD)

2-FULL NAME Albert Devers

(a) RESIDENCE NO 113 N Pratt St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) /
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant .....
(Address) Home

15 OCT 2 - 1924 1826 ROBERT R. KRAUTER, Registrar.
THE MORGUE, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 15 Sept 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.), M. D.

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: OCT 2 1924, 192

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

90717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 90717

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 E. Fayette St. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ross

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1924

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, 16 hrs. of ~~min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Viola Hutchison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed OCT 2 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1924, to Sept. 29, 1924, that I last saw h e alive on Sept. 29, 1924, and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ✓ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ✓ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ✓ Date of .....

Was there an autopsy? ✓

What test confirmed diagnosis? —

(Signed) E. L. Stone, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: OCT 2 1924

20 UNDERTAKER: Robert Hoerle
Per Wm E WOODALL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90718

CERTIFICATE OF DEATH.

1660 D 90718

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Hunter St ST., 17 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnetta Bell Johnson

(a) RESIDENCE NO. 2212 Hunter st ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto- Md

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Johnson
(Address)

15 SEP 12 - 1924 Robert P. Harrison, ... 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1924, to Sept 30, 1924, that I last saw h.e alive on Sept 29, 1924, and that death occurred, on the date stated above, at 9.50 p m.

The CAUSE OF DEATH* was as follows:
Marasmus + Malnutrition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Unsanitary environment + Error (Diet (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Empirical Dgnosis

(Signed) ..... M. D.

. 19 (Address) 4226 Frt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount

DATE OF BURIAL Oct 2 19 24

20 UNDERTAKER John A. Farrell

ADDRESS 2311 Eutaw St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Von Lossberg)

D 90719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Went Balt. general hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Raynor Ave & Dudley St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Vonlossberg.

(a) RESIDENCE No. 628 Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Von Lossberg

6 DATE OF BIRTH (month, day, and year) Dec. 18-1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER John Berg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Krauss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Von Lossberg.

(Address) 628 N Bond St.

15 Filed , 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1924, to Sept. 30, 1924, that I last saw h alive on Sept. 30, 1924, and that death occurred, on the date stated above, at 5:55 a.m.

The CAUSE OF DEATH* was as follows:

Diffuse cellulitis

of left leg.

6 weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes. Date of 9/24/24

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & operative

(Signed) James Hurst Mcpherson, M. D.

19 (Address) Med Bldg John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery. DATE OF BURIAL Oct 3 1924

20 UNDERTAKER Harry H Nitzke ADDRESS 1531 N. Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important See instructions on ba

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90720 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 90720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital. Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Possessowski

(a) Residence No. 722 S. Bethel St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W.

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE about 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Hospital Records

(Address)

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Sept 30, 1924

that I last saw h.. alive on Sept 30, 1924,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physic. Exam.

(Signed) H. B. Seybert M. D.

, 19 (Address) St Jos Hosp Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, National Cemetery — DATE OF BURIAL, Oct 3, 24

20-UNDERTAKER, Henry H. Weitz & Co — ADDRESS 1531 W. Lombard St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90721 D 90721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 E Chase ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac F. Shertzer

(a) RESIDENCE NO. 1812 E Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Shertzer

6 DATE OF BIRTH (month, day, and year) Feb 11 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher 1/2

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Jacob Shertzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Suggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mary Fann Merritt (Address) 1813 E Chase St

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 19 24

17

I HEREBY CERTIFY, That I attended deceased from Sept 12 19 24 to Oct 1st 19 24, that I last saw him alive on Sept 30th 19 24, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Contributory Dyspepsia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis?

(Signed) Coolidge M. D.

1924 (Address) 1001 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Joseph's Church Baltimore	Oct 3 19 24

20 UNDERTAKER H. C. Brooks & Sparkes ADDRESS 1114

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be stated EXACTLY. PHYSICIANS should furnish information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

672 - 1524

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90722

D 90722

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2202 W. Lexington St. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Dorothea E. Langgood

(a) Residence No. 2202 W. Lexington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest B. Langgood

6-DATE OF BIRTH (month, day and year) June 11, 1861

7-AGE. 63 yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) (At Home)

(c) Name of employer

9-BIRTHPLACE (city or town) Catonsville

(State or Country) Baltimore County, Md.

PARENTS.

10-NAME OF FATHER, August G. Knoop

11-BIRTHPLACE OF FATHER (city or t Germany
(State or Country),

12-MAIDEN NAME OF MOTHER Elizabeth Lehn

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14- (Informant) Ernest B. Langgood

(Address) 2202 W. Lexington St.

15- Filed OCT 2 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 2, 1924

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1924 to Oct 2nd, 1924

that I last saw h.. alive on Oct 2, 1924,

and that death occurred, on the date stated above, at 8.50 Am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

10-2-24 (Address) 1127 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	Oct 4 1924
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 W Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17D 90723

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90723

CERTIFICATE OF DEATH.

X113

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2 JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Tofazzychi

(a) RESIDENCE NO. Penn Cars ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Victor Tofazzychi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Victoria Ogonoke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 Oct 3 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 1924, to Oct 2, 1924,

that I last saw h— alive on Oct 2, 1924,

and that death occurred, on the date stated above, at 12 40 a m.

The CAUSE OF DEATH* was as follows:

Diarrhea & vomiting

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter E. Stewart, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Oct 3. 1924

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

CT2 - 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90724 ✓ D 90724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Henneman Ave ST., 8 WARD)

REGISTERED NO. 119

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Ethel Sturgeon

(a) RESIDENCE NO. 1825 Henneman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH. (month, day, and year) Jan 11/1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER George Sturgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hamilton Ont.

12 MAIDEN NAME OF MOTHER Margaret Emma Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant Margaret E. Sturgeon (Mother)

(Address) 1825 Henneman Ave

15 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-inter abdominal hemorrhage-
impacted bowel & probable rupture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congental dilatation of colon-Diag at Hopkins 10 & 5 yrs ago

(Signed) J. F. Mollen, M. D.

(Coroner.)

Oct 1/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 4 1924

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

CT2 - 1924

Spec.—1-10-21—M&T—1500 Blks.

D 90725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90725

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 W. Balto ST. 70 WARD)

2-FULL NAME Joseph V. Lauer

(a) RESIDENCE NO. 2723 W. Balto St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Hogan Lauer

6 DATE OF BIRTH (month, day, and year) aug 1.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .... min.
	35	2 1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 266

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Wholesale

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John R. Lauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Jos. Lauer

(Address) 2723 W. Balto St.

15 FILED OCT 2 1924, 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 19 24

17 I HEREBY CERTIFY, That I attended deceased from March, 19 24, to Sept 29, 19 24, that I last saw h— alive on Sept 29, 19 24, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz M. D.

Oct 1 1924 (Address) 7040 Linton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Oct 3 1924

20 UNDERTAKER Margaret J. Floyd ADDRESS 1422 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

D 90726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90726

CERTIFICATE OF DEATH. (Robinson St.)

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 N Robinson St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... George M Crell .....

(a) Residence No. 528 N Robinson St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Crell

6-DATE OF BIRTH (month, day and year) Sep 3 1880

7-AGE, 44 yrs. mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, John C Crell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Annie Bersa

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant)..... Gerald Crell .....

(Address)..... 528 N Robinson .....

15-

Filed..... Robert P. Harrison, ...
Registrar.

CT2 — 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). September 30 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 — 19 24 to Sept 30 19 24

that I last saw him alive on Sept 30 19 24

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Pul. T.B.

.....

.....

(Duration) 2 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Ca Lung Tone

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? .....

What test confirmed diagnosis? Sputum Findings

(Signed) Walter J. C. Blake M. D.

19- (Address) 1432 N Gay

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Oct 4 ..., 1924
20-UNDERTAKER. Wendell Asspel & Son	ADDRESS 378 Linn

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK. Every question should be carefully answered. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

D 90727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90727

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred. Denhard.

(a) RESIDENCE NO. 901 S. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5 1878

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
46	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Balt., Md.

PARENTS

10 NAME OF FATHER: Adam Denhard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Cardinet Bau...

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Denard

(Address)

15 Filed ..... 1924 ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1924, to Sept. 30, 1924, that I last saw him alive on Sept. 30, 1924, and that death occurred, on the date stated above, at 4.27 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

Final Sepsis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No · Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Austin Peace M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Oct 3 1924

20 UNDERTAKER: W. M. Cook ADDRESS: 502 E. Fort Ave.

OCT 2 - 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

Registered No. 100-001

City of BALTIMORE: (No. ..... St., | V | Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Differderfer, Rebecca T.

(a) Residence No. 2032 N. Calvert St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-Single, Married, (Widowed) or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) (Abstract) 1842

7-AGE. 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town)..... Do
(State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town)..... Do
(State or Country), Do

14- (Informant) Bay View Hospital

(Address) Baltimore, Md.

15- Filed OCT 2 - 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/2/24

17- I HEREBY CERTIFY, That I attended deceased from 9/23/ 1924 to 10/2/ 1924 that I last saw h[illegible] alive on 10/1/24 19.... and that death occurred, on the date stated above, at 5 50 a m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(Duration) — yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab. & clinical findings.

(Signed) H. Goldstein M. D.

10/2, 1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Lorraine Park	Oct 4, 1924
20-UNDERTAKER, H. B. Cook	ADDRESS 302 E. Hoffman Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90729

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Ashton St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F. Kuans

(a) RESIDENCE. No. 2108 Ashton St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Kuans

6 DATE OF BIRTH (month, day, and year) Jan 29-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Granite Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 16

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Kuans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Bean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary F. Kuans
(Address) 2108 Ashton St

15 OCT 2 - 1924 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 2— 1924, to Oct 1— 1924.

that I last saw him alive on Oct 1— 1924.

and that death occurred, on the date stated above, at 9.25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Degeneration

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. Hilbert Hemming, M. D.

Oct 2, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	10-3 1924
20 UNDERTAKER	ADDRESS
Wm Cook	602 [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

[illegible] Deputy Clerk

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90730

D 90730

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] WARD)

2-FULL NAME John J Leonard

(a) RESIDENCE NO. 1813 Monroe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Street Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Michael Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catherine Kuhey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Thos. Drury 1813 Monroe St

15 OCT 3 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Hes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Lung (Contusion)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 1 ds.

(Signed) C Slades, M. D.
(Coroner.)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Oct 3 1924

20 UNDERTAKER: Martin Kuhn — ADDRESS 1820 Aisquith

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90731 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 S. Gilmor St., 19 Ward) Registered No. 16'-08'

2-FULL NAME Beatrice Vogelsang —

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 914 S. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct. 1 - 1924

7-AGE. yrs. 1 mos. ds. If LESS than 1 day, hrs. 9 min. 30

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), 314 S. Gilmor

PARENTS.

10-NAME OF FATHER, Jas. N. Vogelsang.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Grace Dorsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md

14- (Informant) Jas. N. Vogelsang (Address) 314 S. Gilmor

15. Filed OCT 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2 1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1924 to Oct. 2 1924

that I last saw her alive on Oct. 1 1924

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature

Delivery —

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. L. Nuckols, M. D.

, 19 (Address) 130 S. Gilmor

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Peters — DATE OF BURIAL, Oct 3, 1924

20-UNDERTAKER, Mr - Mrs A. S. Finch — ADDRESS 1732 N Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—This [illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90732

CERTIFICATE OF DEATH.

D 90732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9 WARD) —

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Miller

(a) RESIDENCE NO. [illegible] ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Frank Miller

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Nora Adams

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed OCT 3 - 1924 ROBERT N. KNAUTEN Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1924

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19..., to [illegible], 19..., that I last saw h... alive on [illegible], 19..., and that death occurred, on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery (Flexner)

(duration) ..... yrs. ..... mos. 1 X ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund N. Kemper, M. D.

10/1, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: 10/3 1924

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificate.

Cor.—1-12-24—M&T—100 Bks.

D 90733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

REGISTERED No. D 90733

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 27 WARD)

2-FULL NAME James D.Dickerson

(a) RESIDENCE NO. 5 Royston Ave-(Hamilton) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) July 4/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) child
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md

PARENTS

10 NAME OF FATHER James A. Dickerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md

12 MAIDEN NAME OF MOTHER Clara R. Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md

14 Informant James A. Dickerman
(Address) 5 Royston Ave

15 Filed OCT 3 - 1924 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed head -run over by auto-truck.

(Inquest to be held later)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) H H Cale, M. D.
(Coroner.)

10/2/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 10/8 1924

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

Spec.—1-10-21 M&T 1500 Bks.

D 90734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90734

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 E. Lafayette Av ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lorenz

(a) RESIDENCE NO. 2424 E. Lafayette Av. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob. Lorenz

6 DATE OF BIRTH (month, day, and year) Oct. 25, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Fred Lorenz (Address) 2424 E Lafayette Ave

15 Filed OCT 3 - 1924, 19... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/1924

17

I HEREBY CERTIFY, That I attended deceased from 10/1, 1924, to 10/2, 1924, that I last saw h... alive on 10/1, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uremia Apoplexy Nephritis chronic Arteriosclerosis & senile regression

(duration) ... yrs. ... mos 1/2 ds.

CONTRIBUTORY (Secondary) Heart failure & cirrhosis

(duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) ... M. D.

10/2 1924 (Address) 1402 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/5 1924

20 UNDERTAKER George J Ruth

ADDRESS 1738 Halford Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90735

CERTIFICATE OF DEATH.

D 90735

REGISTERED NO. C 100-08

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 S. Bruce St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edward Sullivan Jr

(Residence in Baltimore: No. 334 S. Bruce St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. May 30, 1924
(Month) (Day) (Year)

7-AGE. ... yrs. 4 mos. 1 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John E. Sullivan

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Agnes Nash

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Sullivan

(Address) 334 S. Bruce St.

15. OCT 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 1st, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1924, to Oct 1st 1924, that I saw him alive on Oct 1st 1924, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Measles

..... (Duration) ... yrs. 1 mos. ... ds.

(Signed) W Butler Hauer M. D.

10/1/24, 191... (Address) 1901 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Oct 3, 1924

20-UNDERTAKER John J. Fields — ADDRESS 1200 N Fremont

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 90736

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Carleton ST., 18 WARD)

2-FULL NAME Leroy Maloney

(a) RESIDENCE No. 18 Carleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 31st 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Maloney

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Riley

13 BIRTHPLACE OF MOTHER (city or town) N.Y.
(State or country)

14 Informant Catherine Maloney
(Address) # 18 So. Carleton St

15 Filed ..... 192 .....
HUBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) — yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)

Oct 2 1924 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Oct 4 192
20 UNDERTAKER John F. Fields	ADDRESS 120 N. Howard St

No. 15.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90737 HEALTH DEPARTMENT—CITY OF BALTIMORE 48 D 90737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 London Ave ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Ross.

(a) RESIDENCE. No. 401 London ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Whit	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Ross

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER William Hackley

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER Ann Larson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Miss Mable Ross (Address) 401 London ave

15 Filed OCT 3 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/24

17 I HEREBY CERTIFY, That I attended deceased from April 6 , 1924, to Sept 30 , 1924, that I last saw h[illegible] alive on Sept 30 , 1924, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Cedma - carcinoma of naso-pharynx

(duration) 1 yrs. mon. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Jos. H. Wasin, M. D.

, 19 (Address) 1015 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Good Shepherd Cem	10/3/24
20 UNDERTAKER	ADDRESS
Dimol Earhart	916 Park ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90738

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13 Cedar St. (ST.) Curtis Bay (WARD) 3 Md

2-FULL NAME Alexander Fagan

(a) RESIDENCE. NO. 13 Cedar St. (ST.) Curtis Bay (WARD) Balto.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18/24

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Annie Braumbart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Annie Fagan 13 Cedar St Curtis Bay Balto Md

15 Filed OCT 3 - 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 30th, 1924, to Oct 1st, 1924, that I last saw h living alive on Sept 30th, 1924 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Enteris-Colitis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M. D.

1924 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross AA Co Md	Oct 4 1924

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Eks.

90739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D 90739

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 20 E Lanvale St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Milbourne

(a) Residence No. 18 E Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	W.	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Laura B Milbourne

6-DATE OF BIRTH (month, day and year) Dec 13 1880

7-AGE, 43 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Pen R R

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Chas D Milbourne

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Mary E Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Charles D Milbourne

(Address) 2413 Francis St

15- OCT 3 - 1924 HUBERT S. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1924 to Oct 1 1924

that I last saw him alive on Oct 1 1924

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. A. Lloyd M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Oct 4 1924
20-UNDERTAKER, John F. Denny	ADDRESS 715 Light St.

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D 90740

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1030 N Eden St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Isabella DeLeon Heaving

(a) Residence No.... 1030 N. Eden st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 23 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George J Heaving

6-DATE OF BIRTH (month, day and year) March 8th 1852

7-AGE. 72 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph L Nones

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Spain

12-MAIDEN NAME OF MOTHER. Dominica McCallen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Salem N J.

14- (Informant) Adelaide L Nones

(Address) 1030 N Eden st

15-

Filed..... 192.... ROBT. J. KRAUTER

Registrar.

OCT 3 - 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19...., to Oct 2nd 19 24, that I last saw h...alive on ....., 19...., and that death occurred, on the date stated above, at .....m. The CAUSE OF DEATH* was as follows:

Cardiac Renal

.....(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) ....., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Oct 4th 1924
20-UNDERTAKER,	ADDRESS
George Schulmyer & Sons	126 E Monument st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF ~~DEATH~~ STILL BIRTH No. ~~D 90741~~

REGISTERED No. D 90741

1 PLACE OF DEATH
D 90741
CITY OF BALTIMORE (No.) 2824 Dillon St. 16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Infant Dypsky

(Residence in Baltimore: No. 2824 Dillon St. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	Single

6 DATE OF BIRTH Sept (Month) 29 (Day), 1924 (Year)

7 AGE ..... yrs. 6 hours ..... ds. | If LESS than 1 day, ... hrs. or 1 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) 2824 Dillon

PARENTS

10 NAME OF FATHER Julius Dypsky

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Kath Duka

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julius Dypsky

(Address) 2824 Dillon St

SEP 30 1924 ROBERT R. KRAUTER, Registrar
Filed Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 29 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I saw h..... alive on ....., 191...,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Still Birth
Premature Detachment
Placenta (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Burke M. D.
Sept 29, 1924 (Address) 3042 Hudson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Stanislaus	Sep. 30, 1924
20 UNDERTAKER	**ADDRESS**
Jno. F. McMenamin	1618 Eastern

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90742

CERTIFICATE OF DEATH.

74-001

D 90742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Wilson Terrace ST., 27 WARD)

2-FULL NAME Christina Margaret Fulda

(a) RESIDENCE NO. 12 Wilson Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. A. Fulda

6 DATE OF BIRTH (month, day, and year) May 10-1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Valentine Fetsch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Schellenger

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Chas. A. Fulda
(Address) 12 Wilson Terrace

Filed OCT 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924, to Oct 1, 1924.

that I last saw her alive on Oct 1, 1924.

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D Carre M. D.

, 19 (Address) Carre & Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Oct 6 1924
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	N & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90743

CERTIFICATE OF DEATH.

100-001

D 90743

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2118 Maryland Ave. ST., 12th WARD)

2-FULL NAME Franklin Willard Dryden

(a) RESIDENCE NO. 2118 Maryland Ave. ST., 12th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city of town where death occurred 39 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Minor Dryden

6 DATE OF BIRTH (month, day, and year) Dec. 16th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39 years	9 -	16 -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer Frank W. Dryden & Sons

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Franklin Washington Dryden

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Florence Mitchell Price

13 BIRTHPLACE OF MOTHER (city or town) Charles County (State or country) Maryland

14 Informant Benjamin O. Tucker

(Address) 322 E. Guilford Ave, Baltimore, Md.

15 OCT 3 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 23 1924 to Oct 2 1924 that I last saw h.. alive on Oct 1st 1924 and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? .....Date of.....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert Knickerbocker M. D.

Oct 2 1924 (Address) 711 W. Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 4 1924
20 UNDERTAKER Henry W. Jenkins & Sons	ADDRESS McCulloh & Orchard

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90744

D 90744

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1736 E. Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Kimmett

(a) Residence No. 1736 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Margaret Kimmett

6-DATE OF BIRTH (month, day and year) Nov. 23. 1848

7-AGE. 75 yrs. mos. ds.

If LESS than 1 day. hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer. B & O R.R.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Philip. Kimmett

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Gerner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Family Kimmett

(Address) 1736 E. Chase

OCT 3 - 1924

Registrar.

Build. Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 1, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 years 19.. to Oct 1/24 19..

that I last saw h.. alive on Sept. 29 19.24

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Valv. dis. Heart

Contributory (Secondary) Grippe 2 days

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?* Aut

(Signed) W J Riley, M. D.

Oct 3 1924 (Address) 1639 Bruning

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL, Oct. 4, 1924

20-UNDERTAKER. William G. Schaeffer

ADDRESS 1916 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. IN FILLING OUT THIS CERTIFICATE, PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See should be carefully supplied, so that it may be properly classified. in plain terms, instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90745

CERTIFICATE OF DEATH.

124

D 90745

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2353 Frederick Ave St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sophia Meier

(a) Residence No. 2353 Frederick Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Meier

6-DATE OF BIRTH (month, day and year) Dec 9, 1837

7-AGE, 86 yrs. 10 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, John Eichelberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) John Meier

(Address) 2353 Frederick Ave

OCT 3 - 1924

Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Oct 1, 1924, that I last saw him alive on Oct 1, 1924, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

10/2, 1924 (Address) 541 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Paul's Lutheran Violetville	October 4, 1924
20-UNDERTAKER. George J. Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. All NAMES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-00 D 90746

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33 St and Calvert ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Marvin Hopper

(a) RESIDENCE NO. 1456 Montpelier ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 55 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			55	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Harris Hopper

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Latourneau

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Morris Hopper
(Address) 1456 Montpelier St.

Filed OCT 3 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1924, to Oct 1, 1924, that I last saw him alive on Sept. 30, 1924 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos 55 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Absent heart sounds

(Signed) M. D. Walsh, M. D.

Oct. 1, 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto.

DATE OF BURIAL Oct 4 1924

20 UNDERTAKER H. E. Friedfeld

ADDRESS 914 Arrowsmith Bro

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90747 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D 90747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 515 S. Luzerne ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Hartman

(a) RESIDENCE No. 515 S Luzerne ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Hartman (Deceased)

6 DATE OF BIRTH (month, day, and year) Sept 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Grabenhorst

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant ..... (Address) 515 S. Luzerne Ave.

15 Filed OCT 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2/ 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H C Radcliffe, M. D.
(Coroner.)
Oct 4, 192 (Address) 2236 Eng

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Oct 4 1924
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1199 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 90748
1-PLACE OF DEATH

D 90748
Registered No.

City of BALTIMORE: (No. 25 N. Curley St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma H. Rodrick

(a) Residence No. 25 N. Curley St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 30, 1924

7-AGE. yrs. 1 mos. 2 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edgar V. Rodrick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Eva Myer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Edgar V. Rodrick
(Address) 25 N. Curley

15- Filed OCT 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924 to Oct 2, 1924
that I last saw h.e alive on Oct 1, 1924
and that death occurred, on the date stated above, at 5a m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

10/3, 1924 (Signed) Wallace W White Jr M. D.
(Address) 2800 N Paca St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Emmanuel | DATE OF BURIAL. Oct 3, 1924

20-UNDERTAKER. Zirkler & Zirkler | ADDRESS 1739 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3117 Mc Elderry St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Cross

(a) Residence No. 3117 Mc Elderry St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Kuner

6-DATE OF BIRTH (month, day and year) April 26 1840

7-AGE 84 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Retired Steel worker

(b) General nature of Industry, business, or establishment in which employed (or employer) ..... City

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto City

PARENTS:

10-NAME OF FATHER, John Cross

11-BIRTHPLACE OF FATHER (city or town) (State or Country), —

12-MAIDEN NAME OF MOTHER, Mary —

13-BIRTHPLACE OF MOTHER (city or town), Unknown (State or Country).

14- (Informant) Hetta Greenwood

(Address) 3117 Mc Elderry

15-

Filed ..... 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 2/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1924 to Oct 2 1924

that I last saw h.. alive on Oct 1 1924

and that death occurred, on the date stated above, at 11 20 m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Peck M. D.

10/3, 1924 (Address) 36 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. — DATE OF BURIAL. Oct. 4th 1924

20-UNDERTAKER. Philip Hennig — ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 11 2

D 90750

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 429 N. Dallas St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Baylor .....

(a) Residence No. 429 N. Dallas St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Selena Baylor

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Richmond Va

PARENTS.

10-NAME OF FATHER, John Baylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Richmond Va

12-MAIDEN NAME OF MOTHER, Emma West

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Richmond Va

11- (Informant) Selena Baylor

(Address) 429 N. Dallas St

OCT 3 - 1924

Filed..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1924 to Oct 2 1924, that I last saw him alive on Oct 1 1924, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gastritis

(Duration) ..... yrs. ..... mos. 2 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. E. Thomas, M. D

10-2-1924 (Address) 822 N Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bury cemetery

DATE OF BURIAL. Oct 5, 1924

20-UNDERTAKER. Edward Gregorleons & Co

ADDRESS 1431

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9075I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 9075I

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1344 Druid Hill Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Della Hicks

(a) Residence No. 1344 Druid Hill Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), "

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), "

14- (Informant) Hattie Hicks

(Address) 1344 D. Hill Ave

15- OCT 3 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 30/24

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to Sept 30, 1924, that I last saw h.. alive on Sept 30, 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H S McCard M. D.

10/2 1924 (Address) 2005 D Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Zion

DATE OF BURIAL, Oct 3, 1924

20-UNDERTAKER, Sam M Chase & Son

ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 90752 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 129

D 90752
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Home for the Aged & the M.E. Church St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie E. Krause

(a) Residence No. 400 N. Fulton Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 17, 1844

7-AGE. 80 yrs. 2 mos. 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Gustavus Krause

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Rosina L. Ocks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15- OCT 3 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 3/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 24 to Oct 3d, 19 24

that I last saw h.er alive on Oct 2, 19 24

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy.

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon M. D.

Oct 3. 19 24 (Address) 700 Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	Oct 4 19 24
20-UNDERTAKER, George J. Smith	ADDRESS 1534 Hollins st

N. B.—WRITE PLAINLY, WITH INK. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 90753

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Arthur Klaff.

(a) RESIDENCE NO. 1919 E. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 10 mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 3, 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Isaac Klaff.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Minnie Scherr.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Minnie Klaff. (mother)
(Address) 1919 E. Fayette St.

OCT 3 - 1924
Filed ... 192...

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

Oct. 3, 192 4 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
1919 E. Fayette St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	10/3 1924
20 UNDERTAKER	ADDRESS
S. Sommer & Bro	1127 E Baltimore St

INSTRUCTIONS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90754

CERTIFICATE OF DEATH.

154-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Vol of America Hospital ST. 4 WARD)

2-FULL NAME Francis Carroll Deatley

(a) RESIDENCE. No. Vol. of America Hospital ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30-1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Carroll Deatley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Hohman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mary Hohman
(Address) 1537 N. Carolina st.

15 OCT 3 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 — 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 30, 1924, to Oct 2, 1924, that I last saw h[illegible] alive on Oct 2, 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? congenital

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) A. J. Corney, M. D.

, 19 (Address) Vol. of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 3 1924

20 UNDERTAKER Harry H. Witzke ADDRESS 1538 W Lombard,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Jackson Street. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura F. Smith.

(a) RESIDENCE NO. 1843 Covington St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John W. Smith.

6 DATE OF BIRTH (month, day, and year) June 14, 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Peacock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Henry W. Smith. (son).
(Address) 212 E. Barney St

15 Filed OCT 3 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto C. Reinhardt (Coroner.) M. D.

Oct. 1, 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 4 1924
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

NOTICE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90756

CERTIFICATE OF DEATH.

D 90756

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 E. Eager St. 10 WARD)

2-FULL NAME Dominick Tringale

(Residence in Baltimore: No. 927 E. Eager St. 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 21 (Day) 1901 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvatore Tringale

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sebastianna Tringale

(Address) 526 Fremont st

15-

Filed ..... Robert P. Harrison, ...
Registrar.

OCT 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924 to Oct. 2 1924, that I saw him alive on Oct. 1, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Eugene L. Cassard M. D.

Oct 3, 1924 (Address) Jew Health

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer. DATE OF BURIAL. Oct 4, 1924

20-UNDERTAKER Geo. G. Cook ADDRESS North ave. and Hartford ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 90757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90757

CERTIFICATE OF DEATH.

100 001

1-PLACE OF DEATH Hospital for the Woman of Maryland

CITY OF BALTIMORE: (No. Lafayette & John ST.; 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maizie Leonard

(a) RESIDENCE NO. 2032 W. Fayette St ST., WARD 19th

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Samuel M. Leonard.

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	38	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Joseph A. Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard County. Md.

12 MAIDEN NAME OF MOTHER Jennie Kirkland.

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pa.

14 Informant Edgar J. Litchfield (Address)

15 OCT 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1924, to Oct. 1, 1924, that I last saw her alive on Oct. 1, 1924, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Ventral Post. Operative Hernia Intestinal Adhesions unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown —

Did an operation precede death? Yes Date of Sept. 30, 1924.

Was there an autopsy? No —

What test confirmed diagnosis? Physical Exam. —

(Signed) J. Cagle Warfield, Jr. M. D.

10/3, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10/4th 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun & Hollins

(over)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on ba

Cor.—1-12-23—M&T—100 Bks.

D 90758 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 504 N Pearl ST., 1 WARD)

REGISTERED NO. 134

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A Robinson

(a) RESIDENCE NO 504 N Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Benjamin A Robinson

6 DATE OF BIRTH (month, day, and year) June 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Francis A Thuson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Benjamin A. Robinson (Address) 504 Pearl St

15 Filed OCT 4 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

(Signed) J. C. Blake, M. D.

(Coroner) Oct 3 192 (Address) 2301 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 4 1924

20 UNDERTAKER Samuel Hemsley

ADDRESS 578 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CT4

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90759

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-801

D 90759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. ..... St., 19 ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sanders Homberger

(a) Residence No. 1429 Mc Henry St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) June 6, 1850

7-AGE, 74 yrs. 3 mos. 26 ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) Do (State or ~~Country~~), Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Do (State or ~~Country~~), Md.

14- (Informant) Bay View Hospital

(Address) Baltimore, Md.

15- Filed OCT 4 1924 [illegible] Registrar.

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/2/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1924 to Oct. 2, 1924

that I last saw him alive on Oct. 2, 1924

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) H. Goldsmith M. D.

10/3/, 1924 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Wpkin Halls Md. DATE OF BURIAL, Oct 6, 1924

20-UNDERTAKER: Wm Cook ADDRESS 502 E Northern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Evans
Cory + Foy 16 & 25

D 90760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 901 North Fremont St., 17 Ward) 12

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D Robinson

(a) Residence No. 901 N. Fremont St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edith Robinson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Edith Robinson

(Address) 901 N. Fremont

15- Filed Oct 4 - 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1924 to Oct 2 1924

that I last saw h.. alive on Oct 2 1924

and that death occurred, on the date stated above, at 12:30A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of No

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Geary, M. D

Oct 4 1924 (Address) 101 N Caery

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount | DATE OF BURIAL, Oct 6, 1924

20-UNDERTAKER, Wm Cook | ADDRESS 502 E North Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

Dr Russell Fayette & Milton Ave

D 9076I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9076I

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2541 E. Monument St., 1 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius F. Reuss

(a) Residence No. 2541 E. Monument St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W.	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Reuss

6-DATE OF BIRTH (month, day and year) June 26/1850

7-AGE.	If LESS than 1 day,
74 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Painter

(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), New York (N.Y.

PARENTS.

10-NAME OF FATHER, George Reuss

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Eva Fankouf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Elizabeth Reuss

(Address) 2541 E Monument

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 2/24

17- I HEREBY CERTIFY, That I attended deceased from 9-26, 1924, to 10-2, 1924

that I last saw him alive on 10-2, 1924 and that death occurred, on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Bright's Disease

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Elijah F. Russell M. D

, 19 (Address) 56 N Milton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Oct 4, 1924
20-UNDERTAKER.	ADDRESS
W. H. Cook	502 E Fayette

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Stated EXACTLY. PHYSICIANS Should state CAUSE OF DEATH

Classified. Exact statement of OCCUPATION is very important.

CT

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90762

CERTIFICATE OF DEATH.

D 90762

100-004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital) ST. ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Sodaro

(a) RESIDENCE NO. 1405 E. Baltimore St ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): May 7 1924

7 AGE: Years ... Months 4 Days 25 If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Joseph Sodaro

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angelina Poggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Hospital Record

(Address) .....

15 Filed ... 19 ... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/2/24

17 I HEREBY CERTIFY, That I attended deceased from 9/15/24, 19..., to 10/2/24, 19..., that I last saw her alive on 10/2/24, 19..., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute anemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) A. W. Selby, M. D.

. 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: George J. Ruth — DATE OF BURIAL: 10/3/24 19

20 UNDERTAKER: 1735 Hanford Ave — ADDRESS: 1735 Hanford Ave

Burial Permit Clerk, Holy Redeemer Cemetery.

WRITE PLAINLY, WITH UNFADING INK—THIS DATA WILL BE COPIED EXACTLY. PHYSICIANS and undertakers should be careful to see that the information should be carefully supplied. AGE should be stated

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90763

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 3516 E Fairmont Ave No ..... St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Baby ..... Henry .....

(a) Residence No. 3516 E Fairmont St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 3/24

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 6 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, George F Henry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto,

12-MAIDEN NAME OF MOTHER, M. Jennings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) George F. Henry

(Address) 3516 E. Fairmont Ave

15-

Filed Oct 4 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 3/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3 1924 to Oct 3 1924

that I last saw h[illegible] alive on Oct. 3 1924

and that death occurred, on the date stated above, at 4:40 PM

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Vincent V. Dorka M. D.

19 (Address) 845 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Schwartz Lan — DATE OF BURIAL. Oct 4, 1924

20-UNDERTAKER, Philip Henig — ADDRESS 2016 Orleans St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90764

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 N. Charles St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Rebecca Mason

(a) RESIDENCE NO. 3507 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Samuel Mason

6 DATE OF BIRTH (month, day, and year): Feb 19th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt, Md

PARENTS

10 NAME OF FATHER: Henry Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Rebecca Hause

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs E L. Bartlett

(Address): 601 Roland ave

15 Filed Oct 4 - 1924 Robert P. Harrison, Registrar

Deputy Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Oct 2 1924, that I last saw h alive on Oct 1 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 4 1924
20 UNDERTAKER	ADDRESS
Henry W Jenkins Son & Co	McCulloh & Orchard sts

OCT 4 - 1924

F. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on ba

Spec—12-23-21—E.B.R.S.—400 Eks.

D 90765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90765

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1653 W North Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Virginia Boeckner

(a) Residence No. 1653 W North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married.

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edward Boeckner

6-DATE OF BIRTH (month, day and year) Nov 25 1872

7-AGE.	If LESS than 1 day,
52 yrs. 11 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Godefroy Vierheller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Edward Boeckner

(Address) 1653 W. North Ave

15- Filed ....., 192.... Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

T4 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1924 to Oct 2nd 1924.

that I last saw h.r alive on Oct 2nd 1924.

and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the right breast.

(Duration) 5 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Septicaemia. Dropsy of abdomen. Leg

(Duration) 6 yrs. 6 mos. 6 ds.

18-Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) D. A. Waldran M. D.

, 19 (Address) 210 East Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery | DATE OF BURIAL, Oct 4th 1924

20-UNDERTAKER. Josiah Leyfer | ADDRESS 1600 W North ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 90766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90766

CERTIFICATE OF DEATH.

10 09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Ensor ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cassidy

(a) RESIDENCE NO. 934 Ensor ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Singl.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver of

(b) General nature of industry, business, or establishment in which employed (or employer) Ice wagon

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Michael J. Cassidy

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Gallagher

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mrs Elizabeth Cassidy

(Address) 934 Ensor St

15 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Oct 3, 1924.

that I last saw him alive on Oct 3, 1924.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (a)

Dilatation of Heart.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

(Address) 1707 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Oct. 6 1924
20 UNDERTAKER Henry Koch Son	ADDRESS 1301 E Eager St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90767

CERTIFICATE OF DEATH.

D 90767

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 E. Oliver ST., 8 WARD)

2-FULL NAME Clifford A. Chalmers

(a) RESIDENCE NO. 2035 E. Oliver ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Anna B. Chalmers

6 DATE OF BIRTH (month, day, and year) July 13 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	38	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Philip Chalmers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Vollrath

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Anna B. Chalmers
(Address) 2035 E Oliver St.

15 Filed ....., 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

OCT 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to Oct 3, 1924.

that I last saw him alive on Oct 2, 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Valvular disease of Heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Fred T. Stony M. D.

(Address) 6 E 39 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 6 1924
20 UNDERTAKER	ADDRESS
Henry Hoods Son	1301 E Eager St

IMPORTANT—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will please state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90768

CERTIFICATE OF DEATH.

154 001

D 90768

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 Boone St ST., 9 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ollie Oglesby

(a) RESIDENCE No. 2629 Boone st ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) July 2/24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Botra Oglesby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Mozelle-------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Mozelle Oglesby

(Address) 2629 Boone St

15 Filed ..... 192 Robert P. Harrison, Registrar

T4 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hydrocephalous-operation

3 Weeks ago (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Haller, M. D.

(Coroner.)

10/4/19 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Oct 4 1924

20 UNDERTAKER Mrs J. G. Locke ADDRESS 1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of old state TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 90769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 W. Henrietta St. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marvin Jackson. (C)

(a) RESIDENCE NO. 414 W. Henrietta St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -- --------

6 DATE OF BIRTH (month, day, and year) July, 29, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Williams (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Hattie Jackson (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant Hattie Jackson. (C) mother.
(Address) 414 W. Henrietta St.

15 Filed OCT 4 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct. 3rd., 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 4 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1627 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90770

CERTIFICATE OF DEATH.

REGISTERED NO. 161-004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N.8th St. ST.. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Wagner.

(a) RESIDENCE. No. 140 N.8th St. ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) Oct.2,19 24

7 AGE	Years	Months	Days	If LESS than 1 day, 1 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John A. Wagner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hofstetter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant
(Address)

15 Filed . 19 Robert P. [illegible], Registrar

14 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct.2,1924 19

17 I HEREBY CERTIFY, That I attended deceased from Oct.2,1924 . 19 . to Oct.2,1924 . 19 .
that I last saw h. im alive on Oct.2,1924 . 19 .
and that death occurred, on the date stated above, at 11.30 A. m.
The CAUSE OF DEATH* was as follows:

Premature Infant.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Labor (28 weeks)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Clemens M. D.

10/2.19 24 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Board of Health

DATE OF BURIAL 19

20 UNDERTAKER: Dept. of Health, Per. Wm. E. WOODALL

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90771 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90771

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Biddison

(a) Residence No. 2059 Kennedy St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mch-7-1860

7-AGE, 64 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Driver

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore, Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Albert Biddison

11-BIRTHPLACE OF FATHER (city or town). Balto. Co.,
(State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Mantel

13-BIRTHPLACE OF MOTHER (city or town). Balto., Co.
(State or Country),

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed OCT 4 1924 192..... Robert F. [illegible]
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-2-24

17- I HEREBY CERTIFY, That I attended deceased from 4-29 1924 to 10-2 1924

that I last saw him alive on 10-2 1924

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Aneurism; Myocardial degeneration;

(Duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude 9 Hudson M. D.

10-2, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. Oct-6 1924

20-UNDERTAKER. H. E. Hughes — ADDRESS 432 N. Broadway

should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
should be carefully supplied. AGE should be
in plain terms, so that it may be properly cla
instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90772

CERTIFICATE OF DEATH.

24 113 D 90772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Compton St. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephan L. Ireland.

(a) RESIDENCE NO. 1043 Compton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 14, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or...min.
	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard S Ireland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Bertha A. Gerbig.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Bertha A. Ireland. (mother)
(Address) 1043 Compton St.

15 Filed OCT 4 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Rombard M. D. (Coroner)

Oct. 3rd., 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs.., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	10/4 192 4
20 UNDERTAKER	ADDRESS
I. Frew McCarthy	130 E. Fort

IMPORTANT: Should be Carefully Answered. Exact statement that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90773

D 90773

CERTIFICATE OF DEATH.

161-681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. 8th St. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Wagner

(a) RESIDENCE. NO. 140 N. 8th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER John A. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Hofstetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Robert P. Hofstetter

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

CT4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1924 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1924, 19, to Oct. 2, 1924, 19, that I last saw her alive on Oct. 2, 1924, 19, and that death occurred, on the date stated above, at 12 N. m.

The CAUSE OF DEATH* was as follows:

Premature Infant.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Labor (28 weeks)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Luther Chas. Niemeyer M. D.

10/2 19 24 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Board (Dr Roker)

DATE OF BURIAL: OCT 4 1924

20 UNDERTAKER: Wm. E. Woodall

ADDRESS

Dep. Commissioner Health.

Dep. Wm. E. WOODALL

CERTIFICATE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of [illegible] PA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90774 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90774

CERTIFICATE OF DEATH.

161-004

1-PLACE OF DEATH

City of BALTIMORE: (No. 505 N. Pine St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Gantt

(a) Residence No. 505 N Pine St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10-1-24

7-AGE, ...yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or 30 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Balto., Md.

PARENTS.

10-NAME OF FATHER, Benny Woods

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Florence Gantt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Florence Gantt

(Address) 505 N Pine St.

15- Filed OCT 4 1924, Robert P. Bartlett, Registrar.

T4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-1-24

17- I HEREBY CERTIFY, That I attended deceased from 10-1-, 1924, to....., 19....., that I last saw h[illegible] alive on 10-1-, 1924, and that death occurred, on the date stated above, at 4 30 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) M. Alexander Nowly M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ... 19....

UNDERTAKER, ADDRESS

STATE OF MARYLAND, Commissioner of Health, OCT 4 1924

Per. Wm. R. WOODALL

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D 90775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ~~234 S Castle St~~ 6 ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Kachanowski.

(a) RESIDENCE NO. 234 S Castle St. Hillsboro md ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kachanowski

6 DATE OF BIRTH (month, day, and year) Oct 7 1875

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER J. Nowakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kowkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant J. Kachanowski
(Address) 234 S Castle St

15 ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

T4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 2, 1924.

that I last saw h[illegible] alive on Oct 2, 1924

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

~~Stated~~

Cholelithiasis

Empyema of Gall Bladder not known (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septicemia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Oct 2 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith C. Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Oct 6 1924

20 UNDERTAKER F. W. Ozazewski — ADDRESS 1930 Eastern

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90776 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2025 Stollings St., 70 Ward) Registered No.....

2-FULL NAME... James H. Hughston

(a) Residence No. Wilmington Del. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M. Hughston

6-DATE OF BIRTH (month, day and year) Sept 16 1874

7-AGE, 50 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.
10-NAME OF FATHER, Thos. Hughston
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.
12-MAIDEN NAME OF MOTHER Susan Stevenson
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Lillian M. Hughston
(Address) 2025 Stollings St.

15- FILED 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct - 4-24

I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Oct 3 1924
that I last saw h. alive on Oct 4 1924
and that death occurred, on the date stated above, at 9.30 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible], M. D.
Oct 4, 1924 (Address) 2406 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Wilmington Del DATE OF BURIAL, Oct 4 1924

20-UNDERTAKER, Geo. H. Fenlo ADDRESS 2[illegible] Monroe Av

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 4

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1532 Hollins St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hemmerich

(a) Residence No. 1532 Hollins St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 24-1839

7-AGE, 85 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)..... (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER, George Gebhein

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs E H Reeburn

(Address) 1532 Hollins St

15- Filed Oct 4 1924 Robert P. Harrison Registrar.

T4 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1924, to Oct 4 1924,

that I last saw h... alive on Oct 3 1924,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

Oct 4, 1924 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Ridge Cem — DATE OF BURIAL, Oct 7, 1924

20-UNDERTAKER George J Smith — ADDRESS 1532 Hollins

Please be careful, approximate answers should be avoided. Exact statement of OCCUPATION is very important. Write in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 90778

HEALTH DEPARTMENT—CITY OF BALTIMORE

165 D 90778

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles Edgar Phelps.....

(Residence in Baltimore: No. 105 N. Hilton Street St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. September 1st 1880
(Month) (Day) (Year)

7-AGE. 44 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Mill Hand at
(b) General nature of industry, business, or establishment in which employed (or employer)..... Phoenix Pad Co.

9-BIRTHPLACE, (State or Country). Woodlawn, Maryland

PARENTS.

10-NAME OF FATHER, Joseph T. Phelps

11-BIRTHPLACE OF FATHER, (State or Couutry). Howard County, Maryland

12-MAIDEN NAME OF MOTHER, Rone Herrick

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore County Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Mrs. Geo. E. Jones
(Informant)
105 N. Hilton Avenue
(Address)

15. OCT 4 - 1924 Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John B. Horton M. D.
(Coroner.)

10-3 1924 (Address) Cedar & Curtis Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Oct. 6th 1924

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 90779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90779

1-PLACE OF DEATH

City of BALTIMORE: (No. 315 E Biddle St., 11 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Fahey

(a) Residence No. 315 E Biddle St., 10 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Fahey

6-DATE OF BIRTH (month, day and year) Oct 4th 1866

7-AGE, 57 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... Private family.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Salt Lake City

PARENTS.

10-NAME OF FATHER, Patrick Kavanaugh

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Cork Ireland

12-MAIDEN NAME OF MOTHER, Maria Cadden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Cork Ireland

14- (Informant) Thomas M. Fahey

(Address) 315 E Biddle St

15-

Filed OCT 4 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 3 1924

17- I HEREBY CERTIFY, That I attended deceased from June 10 1924, to Oct 3 1924

that I last saw her alive on Oct 1 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton M. D

Oct 3rd 24 (Address) 700 E Chase St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral	Oct 6, 1924
20-UNDERTAKER.	ADDRESS
Martin Fahey Son	1877 W North

Should be carefully supplied. NOT should be stated. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bkw.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90780

CERTIFICATE OF DEATH.

114 D 90780

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 S Bond ST., 3 WARD)

2-FULL NAME Michael Lomanzewski

(a) RESIDENCE No. 824 S. Bonds ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5d yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
mal	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherin Lomanzewski

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Gunsta
(c) Name of employer - Laborer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lomanzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Catherin Lomanzewski (Address) 824 S Bond St

15 Filed OCT 4 - 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) old age

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Hamber, M. D. (Coroner.)

Oct 4, 1924 (Address) 201 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy-Rosary.	Oct 6. 1924
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Wolfe

CAUSE OF DEATH to be properly classified. Exact statement of ca... TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

D 90781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90781

CERTIFICATE OF DEATH.

161-04

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 S Gilmor St ST., 19 WARD)

2-FULL NAME Anna May Hoensch

(a) RESIDENCE NO. 500 S Gilmor St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3/24

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or 36 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George P Hoensch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Schumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. P. Hoensch

(Address) Robert P. Harrison,

Filed OCT 4 1924, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924, to Oct 3, 1924, that I last saw her alive on Oct 3, 1924, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. V. Goodehaus, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 4 1924
20 UNDERTAKER	ADDRESS
Harry H. Weitzke	153 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90782

CERTIFICATE OF DEATH.

162 D 90782

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Mercy Hospital ST., 13 WARD)

2-FULL NAME Leo Cornish

(a) RESIDENCE No 2337 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4 1824

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Frank Cornish

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elezebeth Murry

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Treasa Herbert
(Address) 2337 Druid Hill Ave

15 OCT 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st Septic Poison

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected Umbilical Cord 4 Days

(Duration) yrs. mos. ds.

(Signed) M. Gomez M. D.
(Coroner.)

Oct 3, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery

DATE OF BURIAL Oct 5 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 90783

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby Klein

(a) RESIDENCE NO. Hebrew Hosp ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or ~~Divorced~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-2-24

7 AGE — Years | Months | Days 1 day 7 hrs. | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hebrew Hosp.

PARENTS

10 NAME OF FATHER William Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Reba Hark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant ..... (Address) Hebrew Hosp

15 Filed OCT 5 - 1924 19.... HUBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-24 19

17 I HEREBY CERTIFY, That I attended deceased from 10-2-24 19.... to 10-4-24 19....

that I last saw h in alive on 3-4-24 19 24

and that death occurred, on the date stated above, at 3.00 p. m.

The CAUSE OF DEATH* was as follows: Cardiac Failure

1 day-7 hrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Atelectasis.

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Isidor I. Jay M. D.

Oct. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sh.

DATE OF BURIAL 10-5 19 24

20 UNDERTAKER Jacob Levy

ADDRESS 1429 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09

D 90784

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 16 WARD)

2-FULL NAME Joseph Miller

(a) RESIDENCE NO. 1823 E. Fairmount Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? 14 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Toplan

(Address) 1017 N Carey st

15 OCT 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4 1924

17

I HEREBY CERTIFY, That I attended deceased from 9/30/24, 19....., to 10/4, 19 24,

that I last saw him alive on 10/4, 19 24,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Cardiac decompensation

7 days (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Strangulated inguinal hernia

..... (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? At patient's home

Did an operation precede death? Yes Date of 9/30/24

Was there an autopsy? No

What test confirmed diagnosis? Operative procedure

(Signed) Philip Jacobson, M. D.

10/4, 1924 (Address) Mercantile Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 10/5 1924

20 UNDERTAKER S. Levinson & Bro — ADDRESS 1127 E Balto st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90785

CERTIFICATE OF DEATH.

74-001 D 90785

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 E. 33rd St. St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Robert J. Monat

(a) Residence No. 317 E. 33rd St. St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Monat

6-DATE OF BIRTH (month, day and year) Sept 16, 1879

7-AGE. 45 yrs. 0 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)..... Steff Piano Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Joseph Monat

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Unknown Doyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Elizabeth Monat

(Address) 317 E. 33rd St

OCT 5 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 26 1924 to Oct 4 1924 that I last saw h. alive on Oct 3rd 1924 and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
causing Rt sided Hemiplegia
due to Chronic Syphilis

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Syphilitic Nephritis and Hypertension

(Duration) Unknown ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferis Busk M. D.

Oct 4, 1924 (Address) 2846 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Oct 6, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sandel & Sons	1710 Eutaw St

Should be carefully supplied. Also should be properly classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90786

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 E Preston St., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dorothy Kraft

(a) RESIDENCE NO. 2028 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian D. Kraft

6 DATE OF BIRTH (month, day, and year) June 7 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian D. Kraft

(Address) 2028 E. Preston St.

15 Filed OCT 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 3, 1924, that I last saw her alive on Oct 3, 1924, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Heart block

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Pathological Signs

What test confirmed diagnosis? Per min 35

(Signed) Frederick L. Kerner M. D.

Oct. 19 24 (Address) 1301 N Dart St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Oct 6 1924
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 90787
Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 2318 Eager Place St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Keerely

(a) Residence No. 2318 Eager Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred Keerely

6-DATE OF BIRTH (month, day and year) Aug 6 1888

7-AGE. 36 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS:
10-NAME OF FATHER, Fred Koberg
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia
12-MAIDEN NAME OF MOTHER, Not known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Fred Keerely
(Address) 2318 Eager St

OCT 5 1924

ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 3/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1924 to Oct 5 1924 that I last saw h in alive on Oct 2 1924 and that death occurred, on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Mitral Regurgitation
of the Heart
(Duration) yrs. 1 mos. 3 ds.
CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [illegible] M. D.
(Address) 2000 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, Oct 6, 1924

20-UNDERTAKER, Fred Ernst & Son — ADDRESS 1906 Eastern Ave

Should be carefully supplied, and the answers written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90788

CERTIFICATE OF DEATH.

31 D 90788

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Argyle Ave ST., 14 WARD)

2-FULL NAME Annie R Burris

(a) RESIDENCE NO. 1530 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles Burris

6 DATE OF BIRTH (month, day, and year): May 24 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): St Mary's Co Md

PARENTS

10 NAME OF FATHER: McGuire Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Mary's Co Md

14 Informant (Address): Jane Harris 1530 Argyle Ave

OCT 5 - 1924

ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1924, to October 3, 1924, that I last saw h[illegible] alive on Oct 2, 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Revelle M.D.

Oct. 4, 1924 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph's St Mary's	Oct 6 1924
20 UNDERTAKER	ADDRESS
Sam'l N. Cruse & Son	400 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Michael . Kulinski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90789

CERTIFICATE OF DEATH.

43

D 90789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 S. Ann ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michal Kulinski

(a) RESIDENCE No. 806 S. Ann ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Kulinski

6 DATE OF BIRTH (month, day, and year) June 2 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe house

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Mich. Kulinski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Antonia Magnet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Julia Kulinski (Address) 806 S. Ann

15 Filed OCT 5 1924 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Sept 27, 1924.

that I last saw h/his alive on Sept 24, 1924

and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Tongue

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal stenosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cancer of the tongue

(Signed) L. L. Emanuel M. D.

10-2, 1924 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Oct 6 1924

20 UNDERTAKER John A Weber — ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90790

CERTIFICATE OF DEATH.

D 90790

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene Sts. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Keyes

(a) RESIDENCE NO. Monkton - Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant -

6 DATE OF BIRTH (month, day, and year): Aug. 1924.

7 AGE: Years | Months: 2 mo | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia -

PARENTS

10 NAME OF FATHER: Ernest Keyes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Bessie Mistred

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: University Hospital Records.

(Address)

15 Filed [illegible] 1924 BERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4- 1924

17

I HEREBY CERTIFY, That I attended deceased from 9-29- , 1924, to 10-4 , 1924.

that I last saw him alive on 10-4 , 1924.

and that death occurred, on the date stated above, at 7 a.m. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition - Marasmus 1 month (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Edwards, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Church Cem. | DATE OF BURIAL: Oct 6 1924

20 UNDERTAKER: W. C. Brooks | ADDRESS: Sparks Md

AGE should be carefully supplied. Any information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90791

CERTIFICATE OF DEATH.

D 90791

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eliza Haywood

(a) Residence No. Fallsbee W. Va St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed and married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England.

PARENTS.

10-NAME OF FATHER Edward Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER, Eliza Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14- (Informant) Eliza Haywood

(Address) Fallsbee West Va

15- Filed OCT 5 - 1924 ROBERT R. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 4th, 1924, that I last saw her alive on Oct 4th, 1924, and that death occurred, on the date stated above, at 11.55 A.m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. 2 mos. days

CONTRIBUTORY (Secondary) Carcinomatosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) L. Clowes Cohn M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cumnagie Pa — DATE OF BURIAL. Oct 6, 19 24

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 1822 W North ave

Should be clearly supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90792

CERTIFICATE OF DEATH.

90 D 90792

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 Hamilton St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Frederick Link

(a) Residence No. 1109 Hamilton St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6-DATE OF BIRTH (month, day and year) Sept 21 1900

7-AGE, 24 yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Elect. Welder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer. Bethlehem Steel Co

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Unk Knox

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unk Knox.

12-MAIDEN NAME OF MOTHER. Unk Knox

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unk Knox.

14- (Informant) Margaret Link

(Address) 1109 Hamilton St

15- FILED OCT 5 - 1924 ROBERT N. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1924 to Oct 3 1924

that I last saw him alive on Oct 2 1924

and that death occurred, on the date stated above, at 1-20 a m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic insufficiency

Mitral Stenosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Glomerulo nephritis - Resulting from Exposure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R Motley Hoag M. D

Oct 3 1924 (Address) 729 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill DATE OF BURIAL. Oct 6, 1924

20-UNDERTAKER. Wm Cook & Son ADDRESS Eaton

Should be carefully answered. Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 90793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 90793

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 77 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Marshal

(a) RESIDENCE No. 626 Portland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 15, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ellsworth Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hazel Marshall (Address) 626 Portland St

15 OCT 5 - 1924 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 4, 1924.

that I last saw her alive on Oct 4, 1924

and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) acute appendix.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 2-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Edwards, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 6 1924
20 UNDERTAKER W. J. Cook	ADDRESS 502 E Baltimore

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90794

CERTIFICATE OF DEATH.

185 D 90794

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 Parkin St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Lynch

(a) Residence No. 129 Parkin St., Ward S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Patrick Lynch

6-DATE OF BIRTH (month, day and year) Dec 23 - 1844

7-AGE. 79 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): S. Carolina

PARENTS.

10-NAME OF FATHER: Thos. Bolger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Carolina Russel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unk.

14- (Informant): Mr. John A. Lynch

(Address): 129 Parkin St.

15- FILED OCT 5 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 28 1924 to Oct. 4 1924

that I last saw her alive on Oct. 4 1924

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) C. V. & E. Abscess & Stork due to Fall Sept.

(Duration) ... yrs. ... mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urin. Analysis etc.

10/4/24 (Signed) Thos. Norton, M. D.

(Address) 888 W. Lombard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: W. Baltimore Cem. — DATE OF BURIAL, Oct ... 1924

20-UNDERTAKER: John G. Cowan & Son, per G. J. Cowan — ADDRESS 901 Hollins St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 90795 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

5/ D 90795

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 E Biddle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Davis

(a) RESIDENCE. No. 1931 E Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Davis

6 DATE OF BIRTH (month, day, and year) Jan 10 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marlboro Co. Va

PARENTS

10 NAME OF FATHER Phil Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary S. Branch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Davis (Address) 1931 E. Biddle

15 OCT 5 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 3, 1924

that I last saw him alive on Oct 3, 1924

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. mos. 1 y ds.

18 Where was disease contracted if not at place of death? Sparrows Pt Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) H. L. Woodridge, M. D.

9-5, 1924 (Address) 1028 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Oct 6 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1224 Richland ave

...mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 90796

D 90796

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1207 Bruce St. 21 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. W. Higdon

(a) Residence No. 1207 Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6-DATE OF BIRTH (month, day and year) Nov. 12 1835

7-AGE 89 yrs. 10 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14-(Informant) Edwd E. Bratton

(Address) 1012 N. Carey St.

15- OCT 5 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1924 to Oct 4 1924

that I last saw her alive on Oct 4 1924

and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Ker de Bram, M. D

, 19 (Address) 1709 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lindon Park Cem. DATE OF BURIAL, Oct 6 1924

20-UNDERTAKER Wm Cole Sons ADDRESS 21 E. Lex

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ ✓ ✓ 105D 90797

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 12 ST., WARD)

2-FULL NAME Mrs. Thos. B. White

(a) RESIDENCE No. Oxford, N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. B. White

6 DATE OF BIRTH (month, day, and year): Sept 12 1865

7 AGE: 59 Years | Months | 23 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: J. T. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Helen George

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Mrs Thos Taylor

(Address) Oxford N.C.

OCT 5 - 1924 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1924, to Oct. 4, 1924.

that I last saw her alive on Oct 4, 1924

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Asthma

(duration) about 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oxford N.C.

DATE OF BURIAL: Oct 6 1924

20 UNDERTAKER: John Mitchell

ADDRESS: Rollins Funeral Home

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90798

CERTIFICATE OF DEATH.

D 90798

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Bamford.

(a) RESIDENCE: No. Trout Cave, Temp abode ST. Freeland, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Bamford.

6 DATE OF BIRTH (month, day, and year) Sept 16 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kluppany N.J.

PARENTS

10 NAME OF FATHER James Dowe

11 BIRTHPLACE OF FATHER (city or town) Bury (State or country) England

12 MAIDEN NAME OF MOTHER Christian Kenyon

13 BIRTHPLACE OF MOTHER (city or town) Bury (State or country) England

14 Informant Frank Dowe (Address) Freeland. Md

15 OCT 5 - 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Placenta Prev.

(duration) yrs. mos. 5 hrs.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) J. S. Cullow i Platt M. D.
(Coroner)

Oct 5 1924 (Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa — DATE OF BURIAL 10/5 1924

20 UNDERTAKER Hartenstein Homemaker. — ADDRESS Md Lens Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3003 Matthew St. St., 9 Ward)

Registered No.

2-FULL NAME Clemmenda Kauffmann

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Penna.

(a) Residence No. 3003 Matthew St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emanuel Kauffmann

6-DATE OF BIRTH (month, day and year) Nov. 23, 1855

7-AGE. 79 yrs. 10 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Lancaster Co. Pennsylvania

PARENTS.

10-NAME OF FATHER. Jacob Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Holland

12-MAIDEN NAME OF MOTHER. Mouse

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Lancaster Co. Pennsylvania

11- (Informant) Samuel H. Peters

(Address) 3003 Matthew St.

12 OCT 6 - 1924 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 24 to Oct 4 1924

that I last saw h.. alive on Oct 4 1924

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) not ascertained yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene Left Hand & Arm

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Findings

(Signed) H. L. Reckard M. D.

10-5-1924 (Address) 3700 Abell Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Penna	Oct 6 1924
20-UNDERTAKER. William Cook	ADDRESS 502 E N nth

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Wms

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90800

CERTIFICATE OF DEATH.

160 D 90800

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 111—N 23 St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennie Lee Winns

(a) Residence No. 111—N 23 St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Winns

6-DATE OF BIRTH (month, day and year) Sept. 28 1924

7-AGE, ...yrs. ....mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Mary Winns

11-BIRTHPLACE OF FATHER (city or town) (State or Country) South Carolina

12-MAIDEN NAME OF MOTHER Sarah Frazier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) South Carolina

14-(Informant) Mary Winns

(Address) 111—N 23 St.

15-OCT 6 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4. 1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 4- 8 A.M. to Oct. 8 P.M. 19..

that I last saw h[illegible] alive on Oct 4 19 24

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Long other cause unknown

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) R. Garland Kahlmeyer M. D.

Oct 5 19 (Address) 1534 E. 4 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel — DATE OF BURIAL, Oct 6th 1924

20-UNDERTAKER, Joseph A Farrell — ADDRESS 2319 Division st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90801

CERTIFICATE OF DEATH.

100-001

D 90801

1-PLACE OF DEATH West Baltimore general Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Rayner Ave & Dukeland St. ST., WARD)

2-FULL NAME Nellie Beverly

(a) RESIDENCE NO. 666 Rayberg St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of: infant.

6 DATE OF BIRTH (month, day, and year): Aug 23 1922

7 AGE: 2 Years, Months 1, Days 10. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Irving Beverly

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 NAME OF MOTHER: Alice Beverly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Alice Beverly 666 Rayberg St

15 Filed OCT 6 - 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/24 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/3/24 , 1924 , to 10/3/24 , 1924 , that I last saw her alive on 10/3/24 , 1924 , and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH* was as follows:

Bilateral Bronchial pneumonia.

(duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) Jos Hubert Wilkerson, M. D.

(Address) West Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 10-6-24

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Penna Ave

Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90802 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-096

D 90802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Etting St., 14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Mason

(a) RESIDENCE No. 1612 Etting St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 886
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Allie Brooks

(Address) 136 Bruns St

OCT 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo Conrad Stake, M. D. (Coroner)

Oct 5 1924 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant

DATE OF BURIAL 10/6/1924

20 UNDERTAKER Daniel Easton

ADDRESS 976 Lemmon

TION is very important. See instructions on back of certificate

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90803
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31

D 90803
Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Hall

(a) Residence No. 9 N. Amity st. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis Hall

6-DATE OF BIRTH (month, day and year): 1867

7-AGE: 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Danial Lee

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Phelps

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Annapolis Maryland

11-
(Informant): Hospital Records
(Address): M.T.H.

12-
OCT 6 - 1924
ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2 1924 to Oct. 2 1924, that I last saw her alive on Oct. 2 1924 and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation with pulmonary oedema.
(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic myocarditis; chronic nephritis (Duration) Unknown mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard Khor, M. D.
10-3, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: at Northwestern [illegible] — DATE OF BURIAL, Oct 6 1924

20-UNDERTAKER: Brown & Sudars — ADDRESS 1144 W Lafayette

If not buried in Baltimore City, so that it may be properly classified. Exact statement of OCCUPATION is very important. See plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90804

CERTIFICATE OF DEATH.

100-001

D 90804

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Loyd Street ST., 3 WARD)

2-FULL NAME Aaron Kraveth Kraveth

(a) RESIDENCE No. 127 Loyd Street ST., 3 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Kraveth

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant [illegible] Loyd [illegible]

(Address)

15 Filed OCT 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/1924

17

I HEREBY CERTIFY, That I attended deceased from 10/3, 19 24 to 10/5, 19 24

that I last saw him alive on 10/5, 19 24

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

Terminal Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Volvulus of intestine

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 10/3/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrersburg Cem.	10/7 1924
20 UNDERTAKER	ADDRESS
Jack Levin	1409 E Balt

mation should be carefully supplied. AGE should be stated EXACTLY. Any information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90805 CERTIFICATE OF DEATH. 57 D 90805

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 22 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Simon

(a) RESIDENCE NO. 709 S. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Simon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Rose Rosenberg

15 OCT 6 - 1924 16 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from September 10, 1924, to October 5, 1924, that I last saw him alive on October 5, 1924, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidore I. Jay, M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock, Pa

DATE OF BURIAL 10/6 1924

20 UNDERTAKER Jack Lewis 1429 E Balto St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90806

D 90806

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 15 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Fogarty

(a) RESIDENCE NO. 3836 Cottage Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Lamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hebrew Records

15 OCT 6 - 1924 Registrar

ROBERT A. KRAUTER, Social Format Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1924, to Oct. 6, 1924, that I last saw him alive on Oct. 6, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, myocarditis, nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor J. Fogy M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nursing Rm. DATE OF BURIAL 10/6 1924

20 UNDERTAKER Jack Levis ADDRESS 1409 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. THOROUGH answer in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90807

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 90807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Goldberg

(a) RESIDENCE NO. 107 N. Ann ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	(W)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant

(Address)

15 OCT 6 1924 Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/3/24, 1924, to 10/5/24, 1924, that I last saw h[illegible] alive on 10/5, 1924 and that death occurred, on the date stated above, at 4:05 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) 0 yrs. 0 mos 6 ds.

CONTRIBUTORY (Secondary) Edema of the lungs

(duration) 0 yrs. 0 mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Isidor L. Fury M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Sanitarium

DATE OF BURIAL 10/6 1924

20 UNDERTAKER Isaac Lewis, 1409

ADDRESS Fleet

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90808

CERTIFICATE OF DEATH.

3 D 90808

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) (St., Municipal Tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lizzie Martin

(a) Residence No. 502 Montgomery st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of not stated

6-DATE OF BIRTH (month, day and year) 1896

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Henson Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Lucy Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed OCT 6 - 1924 ROBERT A. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 9, 1924 to Oct. 2, 1924

that I last saw her alive on Oct. 2, 1924

and that death occurred, on the date stated above, at 4.45a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Laryngeal tuberculosis

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) Richard Schor M. D.

10-2-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn DATE OF BURIAL, Oct 6 1924

20-UNDERTAKER. S. S. Brown & Son ADDRESS 1520 Penna. Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

173239 38

D 90809 REGISTERED NO. D 90809

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Gross

(a) RESIDENCE NO. 151 W Hamburg St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 24, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Tony Morales

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Edith Gross

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 6 - 1924 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1924, to Oct 5, 1924, that I last saw h alive on Oct 5, 1924, and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Acute meningitis (pneumococcus?)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis media (2 wks) Congenital syphilis — Life
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H Kuper, M. D.

10/5, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 6 1924
20 UNDERTAKER	ADDRESS
H L Broumel Son	108 W Mond

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... at it may be properly classified. Exact statement of OCCUPA- ... s on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90810

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1831 Hope ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Van Order

(a) RESIDENCE NO. 1821 Hope ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of E-Van Order

6 DATE OF BIRTH (month, day, and year) Sept 30-850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Howard Van Order

(Address) 15 Caroline St

15 Filed OCT 6 - 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1924, to Oct. 4, 1924, that I last saw her alive on Oct. 3, 1924, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Benj. F. Hayden, M. D.

10/6, 1924 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Near Cathedral — DATE OF BURIAL Oct 7 1924

20 UNDERTAKER Tom Cook — ADDRESS 502 E Monte

CAUSE OF DEATH should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 9081 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9081

CERTIFICATE OF DEATH.

REGISTERED NO. 185

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No.) University Hospital ST., WARD)

2-FULL NAME William Council

(a) RESIDENCE No. 622 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Colrad	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Council

6 DATE OF BIRTH (month, day, and year) 3/12/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ship Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Reuben Council

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Laura Council (Address) 622 N. Eldersly

15 Filed ROBERT R. KRAUTER OCT 6 - 1924 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Investigation find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Base of Skull fall down Hatteway & Boat accident

(duration) 3 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James McReuben, M. D. (Coroner.)

Oct 6, 1924 (Address) York Chase H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fayetteville N.C. DATE OF BURIAL Oct. 6 1924

20 UNDERTAKER Thos J. G. Lockes ADDRESS 1302 Jefferson

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 90812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15 WARD)

2-FULL NAME Arthur Sommerville

(a) RESIDENCE NO. 727 Deborah ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Frank Sommerville

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Friend

(Address) JOHNS HOPKINS HOSPITAL

15 OCT 6 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 3, 1924, that I last saw him alive on Oct 3, 1924, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis Septicemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen, M. D.

Oct 8th 1924 (Address) Johns Hopkins Hospital. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct. 6 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90813

CERTIFICATE OF DEATH.

D 90813

1-PLACE OF DEATH

City of BALTIMORE: (No. 834 Aisquith Street St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert C. Belt

(a) Residence No. 834 Aisquith Street, St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes Belt

6-DATE OF BIRTH (month, day and year): 8/15/1882

7-AGE: 42 yrs. 1 mos. 17 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: George W. Belt

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Emma C. Treadway

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14-

(Informant): Mrs. Mamie Eck

(Address): 1503 E. Lanvale Street

15-

Filed OCT 6 - 1924

ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1924 to Oct 3, 1924,

that I last saw ~~him~~ alive on Oct 2 1924,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion + acute Dilation Heart

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. C. Cameron M. D.

10-6-, 1924 (Address) 1707 N Carlton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL, 10/6/, 1924

20-UNDERTAKER: George F. Ruth

ADDRESS 1735 Harford Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90814

CERTIFICATE OF DEATH.

101-001

D 90814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Carter Street ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Mosley

(a) RESIDENCE NO. 1713 Carter Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Scott Mosley

6 DATE OF BIRTH (month, day, and year) March 15/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buckingham Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Mary Mosley

(Address) 1713 Carter St

15

OCT 6 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1924, to Oct. 4, 1924, that I last saw him alive on Oct. 4, 1924 and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Dwight Forsythe, M. D.

10/6, 1924 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 10/6 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Burial Permit Clerk

Indicate above by a cross (X) any Statistical Supplies Not Known

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90815

D 90815

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hospital For The Women of Maryland ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Helen Fletcher

(a) RESIDENCE NO. Hotel Altamont ST., Eutaw Place WARD Baltimore
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20 / 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Elizabeth
(State or country) New Jersey

PARENTS

10 NAME OF FATHER James Fletcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Elma M. Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wilmington Del

14 Informant J. W. Hazzey
(Address) Hotel Altamont

15 OCT 6 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1924, to Oct 4, 1924,
that I last saw her alive on Oct 3, 1924,
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. —

(Signed) J. Cagle Warfield, Jr. M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 7 1924

20 UNDERTAKER H. W. Jenkins & Son Co

ADDRESS McCulloh & Arlington

MATTER SHOULD BE CAREFULLY SUPPLIED. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90816

CERTIFICATE OF DEATH.

74-001

D 90816

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3935 Frusby St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora A. Clark

(a) Residence No. 3935 Frusby St. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced (HUSBAND of or) WIFE of John K. Clark

6-DATE OF BIRTH (month, day and year) Aug 30-1858

7-AGE. 66 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bath, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) John K. Clark

(Address) Same 3935 Frusby

15- Filed OCT 6 1924 ROBERT R. KRAUS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1924 to Oct 4 1924

that I last saw h[illegible] alive on Oct 4 1924

and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

High Blood Pressure

(Duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) D. V. Bishop M. D

Oct 5 1924 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL, Oct 7 1924

20-UNDERTAKER Wm. Cook ADDRESS 532 E Fayette

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 D 868

D 90817

CERTIFICATE OF DEATH.

D 90817 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1017 S. Fremont Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Tyler

(a) Residence No. 1017 S. Fremont Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary A. Tyler

6-DATE OF BIRTH (month, day and year) Jan 16 1867

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Chas H. Tyler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Henrietta Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14- (Informant) Mary A. Tyler

(Address) 1017 S. Fremont Ave

Oct 4 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1923 to Oct. 4 1924.

that I last saw him alive on Oct. 2, 1924

and that death occurred, on the date stated above, at 1:35 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. 8 mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Humphreys M.D.

10/4 1924 (Address) 1014 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn — DATE OF BURIAL. Oct 7th 1924

20-UNDERTAKER, Clarence E. Wright — ADDRESS Baltimore

Buried Parish Date

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90818

175 09

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 90818

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

2-FULL NAME Roland Coffay

(a) RESIDENCE No. 713 E Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Jos. Coffay

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Ena Knowings

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 6 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 29 1924 to Oct 4 1924, that I last saw him alive on Oct 4 1924, and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute infection of ear
Mast.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Staph. aureus septicaemia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 30. 24

Was there an autopsy? Yes Mastoid

What test confirmed diagnosis? Blood culture

(Signed) Reynold E. Leonard, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Oct 7 1924
20 UNDERTAKER Robt J Turner Jr.	ADDRESS 1442 N. Broadway

Information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D 90819

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Dickens

(a) RESIDENCE NO. Dublin, Ga. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marguerite B. Dickens

6 DATE OF BIRTH (month, day, and year) Sept 8. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John H. Dickens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Hatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Marguerite B. Dickens (Address) Dublin Ga.

15 Filed OCT 6 - 1924, 19 ROBERT R. KRAETER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/3, 1924, to 10/6, 1924, that I last saw him alive on 10/6, 1924, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas

(duration) yrs. 6+ mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Halcyon Ga. DATE OF BURIAL Oct 6 1924

20 UNDERTAKER John O'Mitchell ADDRESS 1201 W. Fayette

AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90820 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90820

14534

CERTIFICATE OF DEATH. D 9382

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

2-FULL NAME Edith C Church

(a) RESIDENCE NO. Washington. D.C ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred = yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William Church

6 DATE OF BIRTH (month, day, and year): May 7 - 1871

7 AGE: Years 53 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER Abram Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER Frances Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 OCT 5 - 1924 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1924, to Oct 5, 1924, that I last saw him alive on Oct 5 - 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of large intestine

Metastasis to liver

Pulmonary embolism

Peritonitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): as above

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Oct. 1 1924

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Thos Harrold, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nantucket Mass

DATE OF BURIAL: Oct 6 1924

20 UNDERTAKER: John O Mitchell

ADDRESS: 1201 W Fayette

Information should be carefully supplied. Exact statement of OCCUPATION should be given. Also CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Hilse

90821 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4709 Eastern Ave St., No 57 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Minna Hilse

(a) Residence No.... 4709 Eastern ave St.,.....Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank A Hilse.

6-DATE OF BIRTH (month, day and year) Jan 18-1850

7-AGE, 74 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, — Nauman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea Kuon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Stolle

(Address) 4709 Eastern ave

15- FILED OCT 6 - 1924 ROBERT J. KRAUTER, Registrar. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 4/1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 29- 19 24 to Oct 4- 19 24

that I last saw h[e] alive on Oct 4- 19 24

and that death occurred, on the date stated above, at 5.10 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

Foot (R) (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W. Herrmann M. D.

10-4-24 (Address) 1913 E. Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL, Oct 6, 1924

20-UNDERTAKER John Weis & Son

ADDRESS 2008 Orleans

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1500 D 90822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 1/2

D 90822

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Anna Grimes

(a) RESIDENCE NO. 412 Frederick ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 11 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Clarence Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Frances Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records Johns Hopkins Hosp

(Address)

15 OCT 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 - 1924 to Oct 3 - 1924

that I last saw him alive on Oct 3 - 1924

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and vomiting

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Furunculosis

(duration) ... yrs. ... mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund Keyser, M. D.

10/4, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: Oct 6 1924

20 UNDERTAKER: John F Denny

ADDRESS: 715 Lex

mation should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90823

CERTIFICATE OF DEATH.

D 90823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 East Cross ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Arnold

(a) RESIDENCE No. 105 East Cross St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Arnold

6 DATE OF BIRTH (month, day, and year) Jan 15 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) (Housework)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John G Arnold Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Schmelz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Bowen

(Address) 105 E Cross St

15 OCT 6 - 1924 ROBERT R. KRAUSER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 4 24, 1924, that I last saw her alive on Oct 4 24, 1924, and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G E Buxton, M. D.

10/5, 1924 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Oct 7 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-00 D 90824

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 27 WARD)

2-FULL NAME Bernard P. Wess

(a) RESIDENCE No. 1 Washington Ave. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	married.

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Rose Catherine Wess

6 DATE OF BIRTH (month, day, and year) Nov. 1 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	35	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at Sta

(b) General nature of industry, business, or establishment in which employed (or employer) Northern Police Station

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Julius G. Wess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary F. Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Catherine Wess
(Address) 1 Washington Ave City

15 Filed OCT 6 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1924 to Oct 5, 1924.

that I last saw him alive on Oct. 5, 1924.

and that death occurred, on the date stated above, at 4.20a m.

The CAUSE OF DEATH* was as follows:

Chronic Gastric Ulcer

Pyloric obstruction

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 3. 24

Was there an autopsy? no

What test confirmed diagnosis? operation, X ray

(Signed) M Edwards. M. D.

Oct. 5th, 1924 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 8 1924
20 UNDERTAKER	**ADDRESS**
Henry Hoeck Son	1301 E Eager st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 90825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90825

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Keyser Pl - ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary. M. Richfield —

(Residence in Baltimore: No. 2114 Keyser Pl. — St.; Lafayette, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 7

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word) Married

6-DATE OF BIRTH, April 5, (Month) (Day) 1856 (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook - Private
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Jno - Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Richfield

(Address) 2118 Keyser St

15- OCT 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct - 4 - (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May - 19 1924, to Oct 4 - 1924, that I saw her alive on Oct - 3 - 24 191.., and that death occurred, on the date stated above, at 5 - 9 - m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia —

a Cardiac disease

(Duration) yrs. 4 - mos. ds.

CONTRIBUTORY (Secondary) Influenza, Heart Disease —

(Duration) yrs. mos. 1 ds.

(Signed) Wash. A. Brasier — M. D.

Oct 6 -, 1924 (Address) 125 E Baltimore —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	10/7/24
20-UNDERTAKER Theodore A White	ADDRESS 1198 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90826 ~~90826~~

CERTIFICATE OF DEATH.

132 D 90826

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mc Bee

(a) RESIDENCE NO. 623 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Mc Bee

6 DATE OF BIRTH (month, day, and year) Feb 14 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. McBee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rel'd (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 6 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Oct 4, 1924, that I last saw him alive on Oct 4 - , 1924, and that death occurred, on the date stated above, at 5.40 p m.

The CAUSE OF DEATH* was as follows:

Vesical calculus

Pyelonephritis

Chronic bronchitis + emphysema.

at least (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? Yes Date of Sept. 19th 24

Was there an autopsy? Yes

What test confirmed diagnosis? Routine path. exam.

(Signed) M. H. Goodman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudoun Park DATE OF BURIAL Oct 7 19 24

UNDERTAKER Wm Cook ADDRESS 502 E North

Mation should be entirely supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 90827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90827

CERTIFICATE OF DEATH.

No 16-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 3420 Toone St., No Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene E. Smith

(a) Residence No. 3420 Toone St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan. 6. 1924

7-AGE, ...yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Harrison P. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Mary E. Yeager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Md.

11- (Informant) Mary E. Smith

(Address) 3420 Toone St.

OCT 6 - 1924

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 4-1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 19 24 to Oct 4 19 24

that I last saw her alive on Oct 4 19 24

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

(Duration) ....yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) ....yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tillow M. D

10/5, 1924 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem. DATE OF BURIAL. Oct. 6, 1924

20-UNDERTAKER, Zinkler + Zinkler ADDRESS 1739 E. Eager St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Co. 1-12-[illegible] Blks.

D 90828

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 90828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S Spring ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frany. W. Diedrich

(a) RESIDENCE No. 4632 Pall Mall ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Colrd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Diedrich

6 DATE OF BIRTH (month, day, and year) Feb 7 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipright
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Carl Diedrich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Diedrich
(Address) 4632 Pall Mall ave

15 OCT 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to h.s death on the day stated above.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acut Dilatation suddden

(duration) yrs. mos. ds.

(Signed) James M Fenlon, M. D.
(Coroner.)
Oct 6, 1924 (Address) 704 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Oct 7, 1924
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓ D 90829

CERTIFICATE OF DEATH.

D 90829

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Thorne of Mr + Mrs Allan Thorne

(a) RESIDENCE NO. 2612 Keyser ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Allan Thrane

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Foundland

12 MAIDEN NAME OF MOTHER Lillian Granslade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Foundland

14 Informant (Address) Mr Allan Thrane 2612 Keyser st

15 OCT 6 - 1924 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 ....., 1924, to 10 - 5 - , 1924, that I last saw him alive on 10 - 5 - , 1924, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

.....

.....

.....

.....(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Maurice Lazenby M. D.

Oct 5, 1924 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 6 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE and PLACE OF BIRTH are important. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90830

CERTIFICATE OF DEATH.

114 D 90830

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Rutland Ave ST., 7 WARD)

2-FULL NAME Freda Collins

(a) RESIDENCE NO. 933 Rutland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Unknown 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	3			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lillian Johnson
(Address) 933 Rutland Ave

Filed OCT 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia -Inanition

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Enteritis for 3 weeks

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Wilson, M. D.
(Coroner.)

10/6/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 6 1924

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Pulaski

CAUSE OF DEATH must be plainly written, so that it can be easily read. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 90831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90831

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Maryland Trust Company.

CITY OF BALTIMORE: (No. Calvert & Redwood Streets. ST., 11 WARD)

2-FULL NAME Horace W. White Jr.

(a) RESIDENCE NO. Garrison Maryland. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 7, 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sales agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer T. H. Symington Co.

9 BIRTHPLACE (city or town) (State or country) Garrison Md.

PARENTS

10 NAME OF FATHER Horace W. White.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Ellin N. Elder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Garrison Md.

14 Informant Jervis Spencer Jr. (Address) Maryland Trust Co.

15 Filed OCT 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull & shine.
Jumped from 10th story window of
Md. Trust Bldg (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
Oct 6, 1924. (Coroner) (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garrison Forrest. DATE OF BURIAL 10/6/1924

20 UNDERTAKER Garrison Funeral Home & Sons Inc ADDRESS 1700 Eutaw & Orchard St

U. S. A.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90832 ✓

D 90832

CERTIFICATE OF DEATH.

90 6

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Pronounce Dead at Hopkins hospital ST., WARD)

2-FULL NAME William Hopkins

(a) RESIDENCE NO. 218 N. Durham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept- 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chef
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph T.H. Rochester

(Address) ~~1413 Jefferson St~~

Robert P. Herrison

Burial Permit Clerk.

T6 - 1924 File, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency -
Probably Valvular

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Collier, M. D.
(Coroner.)

10/6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Oct 8 1924

20 UNDERTAKER Jos. T.H. Rochester

ADDRESS 1413 Jefferson St

CAUSE OF DEATH must be written in plain terms, and must not be indefinite or misleading. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 90833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 N. Fayette ST., 18 WARD)

REGISTERED NO. 18-306

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice D Beisel

(a) RESIDENCE NO 1007 N. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 17 1913

7 AGE: Years 11 Months 2 Days 17 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Ralph Beisel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Zula Hoke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Zula Beisel (Address) 1007 N. Fayette St.

15 F....., 192.. Registrar

6-1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by Submersion Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gas escaped from Water Heater

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D. (Coroner.)

Oct 4 192 4 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Oct 7 192 4

20 UNDERTAKER: Harry Hewitzke — ADDRESS: 1531 W. Lombard St.

THIS IS Very Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90834 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital Registered No. 90

City of BALTIMORE: (No. ..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moran Hovey Klein

(a) Residence No. 1501 W. Lombard St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Klein.

6-DATE OF BIRTH (month, day and year) about 1869

7-AGE. about 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, John Moran

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Henry A. Klein

(Address) 1501 W. Lombard St

15- Filed OCT 6 - 1924 192 ..... Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 19, 1924 to Oct 5, 1924

that I last saw h er alive on Oct 5, 1924

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 5 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) X yrs. X mos. 17 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D.

, 19 (Address) St Jos. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 7, 1924

20-UNDERTAKER, Harry H. Witzke — ADDRESS 1531 W Lombard

Exact statement of OCCUPATION is very important. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90835

CERTIFICATE OF DEATH.

161-04

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Franklin Sq. Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child of Avery A. + Mary A. Gates

(a) Residence No. Same St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	W.	Sin

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 30th 1924

7-AGE.	If LESS than 1 day,
...yrs. ...mos. 5 ds.	...hrs. or. ...min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER, Avery A. Gates

11-BIRTHPLACE OF FATHER (city or town) Greenville S.C. (State or Country),

12-MAIDEN NAME OF MOTHER, Mary A. Chaffin

13-BIRTHPLACE OF MOTHER (city or town) Dallas Md (State or Country),

14- (Informant) Mrs. A. Gates

(Address) Greenville S.C.

15- Filed ..... 19.. Registrar.

Burial Permit Cle

OCT 6 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-5-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1924, to Oct 5, 1924, that I last saw her alive on Oct 5, 1924, and that death occurred, on the date stated above, at 3 30p m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) W. H. Neumeyer, M. D.

, 19 (Address) 1013 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cem	10-7, 19.24
20-UNDERTAKER.	ADDRESS
James Lyman & Son	1000 S Paca St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90836

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospotal ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Williams

(a) RESIDENCE NO. 231 S. Durham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clem Paul Williams

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Walter Sheely alias Shields (Address) 231 S. Durham St.

Filed 1924, 192 Robert P. Harrison, Registrar

THIS MORNING Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis - Caused by brick thrown by Walter Shields on Sept 22/24

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) S. P. Collins, M. D. (Coroner.)

Oct 1/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL OCT 6 1924 192

20 UNDERTAKER ADDRESS

Wm. A. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact date of occurrence must be given. ATTENTION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 191

D 90837

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME John Williams

(a) RESIDENCE NO. 917 Watson St ST., formerly of Miama Fla. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Track Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Sgt. Chas. M. Bavis
(Address) Eastern Police Dist.

Filed OCT 6 1924, 192 Robert P. Harrison, Registrar
(THE MORGUE) Burial Permit Clerk.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~[illegible]~~ inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Thoracic Hemorrhage-Pistol shot by Police Officers while resisting arrest.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. Kolb, M. D.
(Coroner.)
OCTOBER 1/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. DATE OF BURIAL OCT 6 1924

20 UNDERTAKER ..... ADDRESS .....

Per. Wm. A. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Kramer

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1858

7-AGE,	If LESS than 1 day,
66 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Municipal Hospital

(Address) UNIVERSITY OF MARYLAND

15- Filed 1921 Registrar.

Robert [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-3-21

17- I HEREBY CERTIFY, That I attended deceased from 5-20, 19 22 to 10-3, 19 21

that I last saw h[illegible] alive on 10-3, 19 21

and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic

Myocarditis, Hypostatic

[illegible]

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. O. Mayo, M. D.

10-4, 19 21 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, Oct 6 1921

[illegible] Director of Health, 19

20-UNDERTAKER, Por. Wm. B. [illegible] ADDRESS

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT6 - 102

Spec.—1-10-21—M&T—1500 Blks.

(Carrie Ries)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90839

D 90839

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carry Ries

(a) RESIDENCE NO. 1440 CARROLL ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wt	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-10-24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - md

PARENTS

10 NAME OF FATHER Carpus Ries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md-

12 MAIDEN NAME OF MOTHER Lulu BRADY

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md-

14 Informant Mother

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1924 Roberts F. Hart 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-2- , 1924, to 10-4 , 1924, that I last saw h-- alive on 10-4- , 1924, and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Acute enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity & malnutrition (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No-

What test confirmed diagnosis?

(Signed) Edwin B. Jarrett M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 10-6 1924

20 UNDERTAKER

ADDRESS

Commissioner of Health.

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

See affadivit with letter on file Oct 7-1924

D 90840

HEALTH DEPARTMENT—CITY OF BALTIMORE

124

D 90840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Mach (Makuseuicz)

(a) RESIDENCE No. 716 Portland ST., Courtland WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mach Makuseuicz

6 DATE OF BIRTH (month, day, and year) 1874 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer (710 Leman St)

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER ? Makuseuicz Mach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mary Mach Makuseuicz (Address) 716 Portland St

15 Filed ....., 19 Robert P. harrison, Registrar

Burial Permit Clerk.

CT 6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to Oct 4, 1924, that I last saw him alive on Oct 4, 1924, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

Myocardial Failure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 14

Was there an autopsy? No Carcinoma of Gall Bladder

What test confirmed diagnosis?

(Signed) Curtis T. Bauer M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 10/8 1924

20 UNDERTAKER Chas. B. Kuchausleo — ADDRESS 637 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90841 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90841

51

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nora Gorsuch.

(a) RESIDENCE NO. 13 W. 25th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	W	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Social Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known.

12 MAIDEN NAME OF MOTHER Catherine Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Husband (Address)

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/24 19

17

I HEREBY CERTIFY, That I attended deceased from 5/10/24, 19...., to 10/4/24, 19....,

that I last saw her alive on 10/4/24, 19....,

and that death occurred, on the date stated above, at 2 p.-m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(duration) yrs 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) K. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 7 1924

20 UNDERTAKER: Edw. Wingfield Jr. — ADDRESS: 301 E 22

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90842

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pascovich

(a) RESIDENCE No. 2014 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	6	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER Ben Pascovich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Skalinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records

(Address)

15 Filed OCT 6 -1924 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924, to Oct 5, 1924, that I last saw him alive on Oct 5 -, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Convulsions - unexplained

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (over)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H Kemper, M. D.

10/5, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Oct. 7, 1924

20 UNDERTAKER Jno. F. Callaghan — ADDRESS 1618 Eastern Ave

mation should be carefully supplied. Exact statement of OC-
at it may be properly classified.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Cor.—1-12-23—M&T—100 Bks.

D 90843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90843

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 909 Brodley ST., 16 WARD)

2-FULL NAME Wm H. Standiford.

(a) RESIDENCE NO. 909 Brodley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of –

6 DATE OF BIRTH (month, day, and year) Sept 18th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	0	26	

8 OCCUPATION OF DEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Hartford County Md

PARENTS

10 NAME OF FATHER Joseph M Standiford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford Co. Md

12 MAIDEN NAME OF MOTHER Mary Timons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford Co Md

14 Informant Martin F. Cosgrove
(Address) 1164 W. Baltimore St

15 Filed ..... 192 Robert P. Harrison, Registrar

CT6 - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Chronic yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) G. C. Radcliffe, M. D.
(Coroner.)

Oct 6 192 (Address) 143 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREATION OR REMOVAL Mountain Church Cem Co Hartford Co Md DATE OF BURIAL Oct 7th 192 4

20 UNDERTAKER J Schloman & Son ADDRESS 539 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

D 90844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90844

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St., 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Stockmann

(a) RESIDENCE No. 1170 Nanticoke St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl A Stockmann

6 DATE OF BIRTH (month, day, and year) Jan 31. 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Pa.

PARENTS

10 NAME OF FATHER Thomas Worden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address)

15 Filed OCT 6 - 1924, 19 Registrar

Robert P. Harrison.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6- 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-11- 1924, to 10-6- 1924,

that I last saw he alive on 10-6- 1924

and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Disease of heart

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. J. Parr, M. D.

196- 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western cemetery — DATE OF BURIAL Oct 9 1924

20 UNDERTAKER W. H. Cook — ADDRESS 502 E Fort Ave.

mation should be carefully supplied. AGE sub... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on bac...

Cor.—1-12-23—M&T—100 Bks.

Dr Monroe 3632 Reisterstown Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90845

CERTIFICATE OF DEATH.

1802 D 90845

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST., 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Stricker

(a) RESIDENCE No. 5912 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary R Stricker

6 DATE OF BIRTH (month, day, and year) 1044

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United R.R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E Stricker
(Address) 5912 York Road

15 Filed 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CT6

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull due to injuries received in accident

Contributory Accidental

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Houssels, M. D.
(Coroner.)

Oct 6, 1924 (Address) 3632 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys, Govans — DATE OF BURIAL Oct 7 1924

20 UNDERTAKER Wm. Cook — ADDRESS 502 E Monument

REGULATIONS: Blanks should be filled legibly, preferably with typewriter. Avoid abbreviations. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 90846

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 90846

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 North Payson St. 15 WARD)

Registered No. C 90

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James L. Ashburn

(Residence in Baltimore: No. 1509 N. Payson St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	W.	Married

6 DATE OF BIRTH Feb 15, 1924 (Month) (Day) (Year)

7 AGE 71 yrs. 7 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9 BIRTHPLACE (State or country): Va.

PARENTS

10 NAME OF FATHER: Griffin Ashburn

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Lydia Hayden.

13 BIRTHPLACE OF MOTHER (State or country): Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lucy Ashburn

(Address) 1509 Payson St

15 Filed ....., 191.... Robert P. Harrison REGISTRAR

Burial Permit Clerk.

16 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 6, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924 to Oct 6 1924.
that I saw h his alive on Oct 2, 1924.
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows: Oct 6. 1924

Chronic Valvular Myocarditis

(Duration) 5 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Embolus Sudden.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benjamin Stark M. D.

Oct 6, 1924 (Address) 2731 Parkwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Springhill, Va. DATE OF BURIAL Oct 8, 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Hatton

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90847 31 D 90847

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1841 N. Milton Ave ST.; 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August William Luken, Jr.
(Residence in Baltimore: No. 1841 N. Milton Ave St.; 29 yrs., 6 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 22 (Day), 1895 (Year)

7-AGE, 29 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... County Dept.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. August W. Luken

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Co., Maryland

12-MAIDEN NAME OF MOTHER Emma Rinde

13-BIRTHPLACE OF MOTHER (State or Country). Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward C. Luken
(Address) Raspeburg Md

15- Oct. 16 1924 Robert P. Harrison ..... 191.....
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 5 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1924, to Oct. 5, 1924, that I saw him alive on Oct 5 1924, and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ....yrs....mos....7....ds.

CONTRIBUTORY .....
(Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) John R. Heverstroke M. D.
Oct 5, 1924 (Address) 3544 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery
DATE OF BURIAL, Oct. 8, 1924

20-UNDERTAKER E. J. Fanning Son 1938 E. Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each entry must be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90848

CERTIFICATE OF DEATH.

44 D 90848

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 E. Fort Ave ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Yeager

(a) RESIDENCE. No. 743 E Fort Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 2 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Joseph Yeager

6 DATE OF BIRTH (month, day, and year) July 30, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Helen Trust (Address) 743 E Fort Ave

15 Filed ... 19... Robert P. Harrison Registrar

T 6 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924, to Oct 4, 1924

that I last saw her alive on Oct 4, 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 29, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Sidney V. Straith M. D.

(Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	10/7 1924

20 UNDERTAKER E. J. Canning & Son - 1460 Battery Av ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90849

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 90849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Genl Hosp. St., 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles France

(a) RESIDENCE NO. 1721 Covington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger 173

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. A. France

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary E. Mallory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Mary France (Address) 1721 Covington St.

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924, to Oct 5, 1924, that I last saw him alive on Oct 5, 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver (Probably Luetic) with Enlargement of the Spleen

(duration) Unknown yrs. ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? [redacted]

(Signed) C. F. Hoffmann, M. D.

10/6 1924 (Address) 1 E. Randolph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 10/9/1924

20 UNDERTAKER E. J. Fanning & Son - 1400 — ADDRESS Battery Av.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90850

90850

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Jackson Place ST., 6 WARD)

2-FULL NAME Elmer Burbank March

(a) RESIDENCE No. 102 Jackson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Elizabeth March

6 DATE OF BIRTH (month, day, and year) Sept 28 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt Stove Foundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Isaac R. Shepherd

9 BIRTHPLACE (city or town) Kimberton

(State or country) Penna

PARENTS

10 NAME OF FATHER Benjamin March

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah Bush

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country) Penna

14 Informant Anna Elizabeth March

(Address) 102 Jackson Place

15 Robert P. Harrison, Registrar

T6 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/4, 1924, to 10/4, 1924, that I last saw him alive on 10/4, 1924, and that death occurred, on the date stated above, at 11-45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) Years 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspension of Heart action

(Signed) C J Carroll, M. D.

, 19 (Address) 1740 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL Oct 7 1924

20 UNDERTAKER William G. Black — ADDRESS 927 N. Broadway

Information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bka.

D 9085I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 9085I

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4333 Ready Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C.D. Stieff

(a) RESIDENCE NO. 4333 4eady Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Stieff

6 DATE OF BIRTH (month, day, and year) Mar 14/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER John L. Stieff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Hannah A. Clifford

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Elizabeth Stieff

(Address) 4333 Ready Ave

15 Filed ....., 192.. Robert P. Harrison, Registrar

Burial Permit Clerk.

T6 -1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) arteriosclerosis senility

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Watts, M. D.

(Coroner.)

Oct 6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 8 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 N. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 90852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X100-001

D 90852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and ~~number~~.)

2-FULL NAME David ~~Levenson~~ Schneider

(a) RESIDENCE NO. 202 + Delamore Place ST., Brooklyn WARD N Y

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj. Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Horowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 7 - 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924, to Oct 5, 1924, that I last saw h— alive on Oct 5, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - cerebral

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? N Y

Did an operation precede death? Yes Date of Sept 30 '24 Exploratory

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) Warfield M Theobald, M. D.

10/5, 1924 (Address) J H Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N Y	10/7 1924
20 UNDERTAKER Sol Simon & Bro	ADDRESS 1127 E Balto St

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90853

D 90853

CERTIFICATE OF DEATH.

91-007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 W. Lombard ST.; 18 WARD)

2-FULL NAME Margeret Laugelutting.

(a) RESIDENCE. NO. 865. W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Laugelutting

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Muhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz Thyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Laugelutting

(Address) 862 N. Gobleard St.

15 Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Oct 5, 1924, that I last saw h.er alive on Oct 4, 1924, and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

General Senility.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry Laugelutting, M. D.

, 19 (Address) 602 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10/7-24

20 UNDERTAKER Wm J. Tichnor Sons

ADDRESS North Ave

Female

---

mation should be correctly supplied. Any
that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so
TION is very important. See instructions on back of certificates.

[redacted]T—CITY OF BALTIMORE

46 D 90854

[redacted]TIFICATE OF DEATH.

Registered No.....

[redacted]DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Asylum St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Francis

(a) Residence No. 833 Plum Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.) W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878.

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Chestertown Md

PARENTS.

10-NAME OF FATHER Cornelius Boyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Chestertown Md

12-MAIDEN NAME OF MOTHER, Elizabeth Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14-

(Informant) Hospital Records

(Address) Bay View Asylum

15-

F OCT 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5-1924

17- I HEREBY CERTIFY, That I attended deceased from September 19 1924 Oct 5 1924

that I last saw h[illegible] alive on Oct 5 1924

and that death occurred, on the date stated above, at 6 30 a. m.

THE CAUSE OF DEATH* was as follows:

Probable Carcinoma of Cervix & extension into Bladder & generalized Metastasis Secondary infection

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY Terminal Bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Wm A Chaney M. D.

1924 Address Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Oct 7, 1924
20-UNDERTAKER.	ADDRESS
Isaac L Brown & Son	108 W Mont St

Exact statement of OCCUPATION is very important. See that it may be properly classified. in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H P. Co.—1000 Bks.

90855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90855

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Aisquith ST.: 9 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dimothy Stern Brown

(a) RESIDENCE. No. 1530 Aisquith ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. -----

6 DATE OF BIRTH (month, day, and year) March 9, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Timothy S. Brown

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Mary Knight

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Timothy S. Brown Jr.
(Address) 1530 Aisquith St.

Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 5. 1924

17 I HEREBY CERTIFY, That I attended deceased from 2. 1. 1924, to 10. 5. 1924, that I last saw him alive on 10. 4. 24. 1924, and that death occurred, on the date stated above, at 7.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Pylorus Obstruction

(duration) ..... yrs. ..... mos.

CONTRIBUTORY (Secondary) Anuria and Fibrillation Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination & X Ray.

10.5 (Signed) J. Edward Morris, M. D.

1924 (Address) 107 E. west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: 10/8, 1924

20 UNDERTAKER: Henry U. Mears & Son

ADDRESS: 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90856

CERTIFICATE OF DEATH.

129 D 90856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 McTavish St ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Jackson Holly

(a) RESIDENCE NO. L 10 McTavish St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sarah R. Jackson

6 DATE OF BIRTH (month, day, and year) ? ? 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah R. Jackson

(Address) 10 McTavish St.

15 Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 25th 24 to Oct 6, 1924.

that I last saw him alive on Oct 6th. 1924, 19....

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstital Nephritis

(duration) yrs. 5 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Oct 8, 1924

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Frederick Ave.

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90857

CERTIFICATE OF DEATH.

113

D 90857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 Philadelphia ave St., 42 WARD)

2-FULL NAME August C Emkey

(a) RESIDENCE No. 3906 Philadelphia ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4-1924

7 AGE: Years — Months: 6 — Days: 2 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER August C. Emkey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle V Wilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant August C Emkey (Address) 3906 Philadelphia Ave

15 OCT 7 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1924, to 10-6, 1924, that I last saw h.. alive on 10-5, 1924 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Auto Intoxication

(duration) ....yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ....yrs. 1 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Fiedler M. D.

19 (Address) 5323 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr A Garrett Sons — DATE OF BURIAL: Oct 7 1924

20 UNDERTAKER: Wm C. Fiedler & Son — ADDRESS: 5323 Park Ave

Information should be entirely supplied. Exact statement of OCCUPATION is necessary. Avoid use of terms that may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90858

CERTIFICATE OF DEATH.

100-001

D 90858

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2119 Mayer St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Davis Wittig

(a) Residence No. 2119 Mayer St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 26-1923

7-AGE. yrs. 10 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George L. Wittig

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Lillie May Groves

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) George L. Wittig

(Address) 2119 Mayer St

15- OCT 7 - 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5-24

17- I HEREBY CERTIFY, That I attended deceased from Sep 27th, 1924, to Oct 6, 1924, that I last saw her alive on Oct 5, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? None

(Signed) Chas. H. Burbert, M. D.

, 19 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Pratt Cem. DATE OF BURIAL, Oct 7th, 1924

20-UNDERTAKER. Jas E. Miller & Son ADDRESS 2332 Jefferson

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 D 90859

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Regester ST., 8 WARD)

2-FULL NAME Mary H. Goedeke

(a) RESIDENCE NO. 1819 N. Regester ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Aloysius H. Goedeke

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara M. Fragen

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Aloysius H. Goedeke
(Address) 1819 N Regester St

15 Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924, to Oct 6, 1924, that I last saw her alive on Oct 6, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Anterior Poliomyelitis

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) John D. Fraley, M. D.

10/6/1924 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 7 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

INFORMATION should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

that it may be properly classified. Exact statement of OCCUPA-
ns on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90860

CERTIFICATE OF DEATH.

160

D 90860

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018. E. Haffman ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georg - A Huber.

(a) RESIDENCE No. 1018. E. Haffmen ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 10/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	26	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER Andrew Huber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. md.

12 MAIDEN NAME OF MOTHER Rose. R. Wolfe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt md.

14 Informant Andrew Huber.

(Address) 1018 E Haffman

15 OCT 7 - 1924 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1924. to Octo 1924.

that I last saw h in alive on Octo. 1924.

and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Both lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Conjestion Lungs.

Ten days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Riley M. D.

Oct 6. 1924 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cmty. DATE OF BURIAL Oct. 8 1924.

20 UNDERTAKER George J. Ruch ADDRESS 1735 Hayford Ave

mation should be carefully supplied. AGE should be stated EXACTLY, even if only a few hours or days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90861 Sp... ...T—1500 Bks.

SPARROW

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90861

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 Huntington Ave ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Sparrow

(a) RESIDENCE NO. 2822 Huntington Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank A. Sparrow

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Maximer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Frank A. Sparrow
(Address) 2822 Huntington Ave

15 Filed OCT 1. 1924 ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1924, to Oct 5, 1924, that I last saw h alive on Oct 5, 1924, and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Gastro-Intestinal type (duration) yrs. 3 mos 12 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History + Clinical Symptoms

(Signed) Paul Brown, M. D.

10/5. 1924 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 7 1924

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Hall Rd

AGE should be carefully supplied. Information should be stated EXACTLY. Abbreviations should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90862

CERTIFICATE OF DEATH.

74-001

D 90862

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 833 E. 34th St. ST., 13 WARD)

2-FULL NAME Adam J. France

(a) RESIDENCE NO. 833 E. 34th St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria L. France

6 DATE OF BIRTH (month, day, and year): Oct. 13. 1841

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 15 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Penna

PARENTS

10 NAME OF FATHER: Adam France

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Mrs. Maria L. France 833 E. 34th St.

15 OCT 7 - 1924

ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 5 1924

17

I HEREBY CERTIFY, That I attended deceased from October 1, 1924, to October 5, 1924, that I last saw h[illegible] alive on October 5, 1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davis, M. D.

9-6 1924 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury M.E. Kensterstown

DATE OF BURIAL: Oct. 8 1924

UNDERTAKER: Horace F. Burgee

ADDRESS: 363 Hall's Rd.

AGE should be stated EXACTLY. PHYSICIANS should take care that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139

REGISTERED NO. D 90863

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13 WARD)

2-FULL NAME Mrs Edith E. Boyer

(a) RESIDENCE NO. 3319 Chestnut Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 9 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Percy G. Boyer

6 DATE OF BIRTH (month, day, and year) Dec. 19-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33 —	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker.

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 686

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Elizabeth Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Hospital records.

(Address)

15 Filed OCT 7 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1924, to Oct. 6, 1924, that I last saw h alive on Oct. 6, 1924 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Multiple uterine fibroids

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Post operative paralytic ileus

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? yes Date of Oct. 1, 1924

Was there an autopsy? no

What test confirmed diagnosis? Operation & clinical findings

(Signed) George C. Halley M. D.

10/5. 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL Oct. 9 1924

20 UNDERTAKER Horace H. Burgee

ADDRESS 633 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90864

CERTIFICATE OF DEATH.

REGISTERED No. C 6003 90864

1-PLACE OF DEATH Union Memorial Hospital Balto

CITY OF BALTIMORE (No.) ~~2600 Maryland Road~~ ST.; 27 (WARD)

2-FULL NAME Clarence A. Kemp

(Residence in Baltimore: No. 6084 Falls Road

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 00 mos. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 3 (Day), 1879 (Year)

7-AGE, 45 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Alfred Kemp

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co.

12-MAIDEN NAME OF MOTHER Emma Wilhelm

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Estella C Kemp

(Address) 6084 Falls Rd

OCT 1 - 1924

Filed....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 5 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Due to Fall Accident
Accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Morrison M. D.
(Coroner.)

Oct 6, 1924 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge DATE OF BURIAL, Oct 9 1924

20-UNDERTAKER A J Marshall ADDRESS 3539 Falls Rd

D 90865 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90865

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 7 E Woodland Ave ST.: 27 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Englar

(Residence in Baltimore: No. 7 E. Woodland Ave St.; yrs., 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Mar (Month) 7 (Day), 1857 (Year)

7-AGE, 67 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Carroll Co

PARENTS.

10-NAME OF FATHER, Peter Perry

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md

12-MAIDEN NAME OF MOTHER, Mary E. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Carl Englar
(Address) 7 E Woodland Ave

15- Filed OCT 9 1924 ROBERT N. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John A Morrison M. D. (Coroner.)
1924 (Address) 3632 Boston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge
DATE OF BURIAL, Oct 9, 1924
20-UNDERTAKER A S Marshall
ADDRESS 3397 Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

D 90866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90866

CERTIFICATE OF DEATH.

89

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Duke alley ST., 3 WARD)

2-FULL NAME Wm. Johnson

(a) RESIDENCE NO. 1104 Duke alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary J Johnson

6 DATE OF BIRTH (month, day, and year) Cant know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 123

(b) General nature of industry, business, or establishment in which employed (or employer) Bannister Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mary Johnson. 1104 Duke alley

15 Filed OCT 10 1924 ROBERT N. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 19 24.

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 19 24, to Oct 3, 19 24,

that I last saw h alive on Oct 3, 19 24,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris x

Hypostatic Pneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis x

Cardiac Enlargement (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Jones, M. D.

10/6. 1924 (Address) 4 W Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Oct 7 1924

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 325 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90867

CERTIFICATE OF DEATH.

1878 D 90867

1-PLACE OF DEATH City of Baltimore: (No. Mt Gail Hospital St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cabbie Lawrence

(a) RESIDENCE NO. 141 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE C.

5 Single, Married, Widowed, Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE Years 25 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 10 D
(c) Name of employer

9 BIRTHPLACE (city or town) Caroline Co Va.
(State or country)

PARENTS

10 NAME OF FATHER George Lexture

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Bell Parker

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Bell Bagnell
(Address) 141 Bolton St.

OCT 7 - 1924

Filed ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 / 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy & inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident Fractures of Skull

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

(Signed) Geo E Blades, M. D.
(Coroner.)

(Address) 1236 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Caroline Co. Va. DATE OF BURIAL Oct 8 1924

20 UNDERTAKER Mrs. P. A. Elliott ADDRESS 1124 Eutaw St.

CAUSE OF DEATH: This information is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90868

CERTIFICATE OF DEATH.

47 D 90868

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 1126 E. Calvert ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Pettigrew Norte

(a) RESIDENCE No. 1126 E. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10th 1859

7 AGE: Years 65 | Months 6 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER James Heywood Norte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charleston S.C.

12 MAIDEN NAME OF MOTHER Emily Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Va

14 Informant: Louisa K. Dunn

(Address) 1126 E. Calvert St.

Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1924, to Oct 5, 1924, that I last saw h.. alive on Oct. 5, 1924, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (6 years ago - operation - no signs until about 6 months ago. Then general abdominal carcinosis (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinosis. dropsy-Extension (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Frank R. Brush, M. D.

Oct. 6, 19 (Address) 927 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Virginia — DATE OF BURIAL: Oct 7th 1924

20 UNDERTAKER: Henry W. Jenkins Sons Co — ADDRESS: Orchard & Mc Collah Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90869

CERTIFICATE OF DEATH.

D 90869
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Oakdale Road St., Roland Park WARD)

2-FULL NAME Matilda Norris Hyshaw

(a) RESIDENCE NO. 215 Oakdale Road St., Roland Park WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~ Female	White	Married

5a If married, widowed or divorced
~~HUSBAND of~~ (or) WIFE of James Kemp Hyshaw

6 DATE OF BIRTH (month, day, and year) Sept 4th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Henry Norris

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bennett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant William N. Hyshaw
(Address) 29 Alexander St. Princeton N.J.

15 Filed OCT 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 19 2X

17 I HEREBY CERTIFY, That I attended deceased from Oct, 4, 19 2X, to Oct, 5, 19 2X
that I last saw h 2V alive on Oct. 5, 19 2X
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? NC
Did an operation precede death? ... Date of ...
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) Edgar P. Sandrock M. D.
, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Greenmount Cemetery

DATE OF BURIAL
Oct. 7 1924

20 UNDERTAKER
Henry W. Jenkins & Sons

ADDRESS
McCulloh & Orchard Sts.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Sarah E Goodwin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90870

CERTIFICATE OF DEATH.

179 D 90870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 N. Charles ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Charles Goodwin
Sarah E. Goodwin

(a) RESIDENCE No. 3507 N. Charles St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	widowed

5a If ~~married~~ widowed, or ~~divorced~~
~~Husband~~ of Charles Goodwin
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER F. P. Lawrence

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Howard County - Md

12 MAIDEN NAME OF MOTHER Harriet B Thomas

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Prince George County - Md

14 Informant Baldwin Goodwin
(Address) 3401 Greenway, Balto

15 Filed OCT 7 - 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1924

17 I HEREBY CERTIFY, That I attended deceased from SEPT., 1922, to 10-6 1924,

that I last saw her alive on 10-5 1924,

and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS
HYPERTENSION
CHR. NEPHRITIS

(duration) 5(?) yrs. — mos — ds.

CONTRIBUTORY (Secondary) ~~CHR~~ CHOLELITHIASIS

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park. Cem	10/8/1924
20 UNDERTAKER Henry W. Jenkins & Sons Co	ADDRESS Foschard & McCulloh

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 90871 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/90 D 90871

1-PLACE OF DEATH

City of BALTIMORE: (No. 3019 Windsor Ave. St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Greaver

(a) Residence No. 3019 Windsor Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary N. Greaver.

6-DATE OF BIRTH (month, day and year) Dec 10. 1843

7-AGE. 80 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Christian Greaver.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Goebel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Fred'k H. Greaver

(Address) 3019 Windsor Ave

15- Filed OCT 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1924, to Oct 4, 1924, that I last saw him alive on Oct 4, 1924, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 7 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 2 yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) G W Billups, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park | DATE OF BURIAL, Oct. 8, 1924.

20-UNDERTAKER. Wm. Mus J. W. Teufel & Son | ADDRESS 801 W. Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90872

CERTIFICATE OF DEATH.

38 D 90872

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Herring Ct ST., 3 WARD)

2-FULL NAME David Booker

(a) RESIDENCE No 219 Herring Ct ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Booker

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer James Lumber Co

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Braxton
(Address) 219 Herring Court

Filed OCT 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acquirium of Pneumonia
Cystery one day
(Lungs)

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture of Stomach
Same (duration) yrs. mos. ds.

(Signed) James M Fenton, M. D.
(Coroner.)
Oct 6, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Oct 7 1924
20 UNDERTAKER John W Henderson	ADDRESS 1502 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90873

CERTIFICATE OF DEATH.

15 101-001

D 90873

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2121 Clifton Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Glaum

(a) Residence No. 2121 Clifton Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George H Glaum

6-DATE OF BIRTH (month, day and year) Nov. 10 - 1870

7-AGE. 54 yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Charles Rullman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Hiltz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) George H. Glaum

(Address) 2121 Clifton Ave.

15- OCT 7 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 5 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924 to Oct 5, 1924

that I last saw h[illegible] alive on Oct 5, 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bowel Obstruction

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardio-Renal

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G. W. Adelsperger M. D.

10/7/24 (Address) 2757 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Oct 8 1924
20-UNDERTAKER.	ADDRESS
Josiah Lyford	1600 W. North Ave.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 90874

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hosp ST., 10 WARD)

2-FULL NAME Mary Rezek

(a) RESIDENCE NO. 724 Greenmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Rezek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Sophie Jirsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Father) Frank Rezek
(Address) 724 Greenmount Ave

15 OCT 7 - 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1924, to Oct 6, 1924, that I last saw her alive on Oct 6, 1924, and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Tonsillar Pharyngeal & Laryngeal
(died on way to hospital.)
(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Myron G. Tull, M. D.

. 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. A.A. Co, Md	10/7 1924
20 UNDERTAKER	ADDRESS
Henry W. Meanes & Son	805 N. Calvert St.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

90875

CERTIFICATE OF DEATH.

128 D 90875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 - N. Vincent ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Smith

(a) RESIDENCE NO. 213 - N. Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Smith

6 DATE OF BIRTH (month, day, and year) April - 19 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chas. Co. Md

PARENTS

10 NAME OF FATHER Charles Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chas Co Md

12 MAIDEN NAME OF MOTHER Adaline Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chas. Co. Md

14 Informant Minnie Brown, Cousin

(Address) 213 - N. Vincent

15 OCT 7 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Oct 4, 1924.

that I last saw h alive on Oct 1, 1924,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pharyngitis

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) Walter D. Jones, M. D.

, 19 (Address) 1 E. Eu - Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 6, 1924.

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E B.R.S.—400 Eks.

D 90876

HEALTH DEPARTMENT—CITY OF BALTIMORE D 90876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Vincent Infant Asylum St., 14 Ward) Registered No. 760

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmeni Latito

(a) Residence No. Lafayette ave Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 16/24

7-AGE. ....yrs. 21 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pocohantas Va

PARENTS.

10-NAME OF FATHER, Steve Latito

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Gangamie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

11- (Informant) Tony Bus

(Address) 1110 E Lombard St

15- Filed OCT 7 1924 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 7/24

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924 to Oct 7, 1924

that I last saw h. alive on Oct 7, 1924

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Goldsborough M. D.

, 19 (Address) 2923 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Pocohantas Va — DATE OF BURIAL, Oct 7, 1924

20-UNDERTAKER. L Tennor Bro — ADDRESS 1126 E Balto St

OCT 7 - 1924

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Fill instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 90877 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90877

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Linden Ave., St. 14 WARD)

REGISTERED NO. C 77

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Riley Jenkins

(Residence in Baltimore: No. 1735 Linden Ave St.; 4 yrs., 10 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 30th, 1858 (Month) (Day) (Year)

7-AGE, 65 yrs. 10 mos. 7 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Artist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Athens Penna

PARENTS.

10-NAME OF FATHER Constant Metherosan

11-BIRTHPLACE OF FATHER (State or Country), N. J. State

12-MAIDEN NAME OF MOTHER Sarah Niles

13-BIRTHPLACE OF MOTHER (State or Country), N. J. State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. C. Jenkins

(Address) 1735 Linden

15- Filed OCT 7 1924, 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 7th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1924, to Oct 7th 1924, that I saw h[er] alive on Oct 7th 1924, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) .....yrs. .....mos. 28 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) .....yrs. .....mos. 2 da.

(Signed) C. B. Culbertson M. D.

10/7, 1924. (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....da. In the State .....yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington Dc | DATE OF BURIAL, Oct 7, 1924

20-UNDERTAKER Stewart & Mercer Co. | ADDRESS 108 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90878

CERTIFICATE OF DEATH.

113 D 90878

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 W. Heath St. ..... St., 23 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca May Laduce.

(a) Residence No. 106 W. Heath St. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced. (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June, 10, 1924

7-AGE. ..... yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant.

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer. —

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Julius Laduce.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maine.

12-MAIDEN NAME OF MOTHER. Carrie Vogel.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Carrie Laduce.

(Address) 106 W. Heath St.

15- Filed 1924 Robert P. Harrison, 192 ..... Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924 to Oct 6, 1924, that I last saw her alive on Oct 5, 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Kumbly, M. D.

, 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Co. ..... DATE OF BURIAL, ... 1924

20-UNDERTAKER. A. Howard Evans ..... ADDRESS 38 E. Fad Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Christ's Institution Hospital

Registered No.....

City of BALTIMORE: (No. 704 Ensor St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Sachs.

(a) Residence No. Jopper Road. Belair Md St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

8-SEX F

4-COLOR OR RACE, White

~~Single,~~ Married ~~Widowed~~ or ~~Divorced~~. (Write the word.) Married

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of John H Sachs

6-DATE OF BIRTH (month, day and year) Sept 21 1872

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Andrew Gurnhart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Jno H. Sachs

(Address) Jopper Road

15- Filed 10-7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 6-24

I HEREBY CERTIFY, That I attended deceased from Sept 29 - 24 to October 6 - 1924.

that I last saw her alive on October 6 - 1924

and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uteris (Duration) yrs. 7 mos. 10 ds.

18-Where was disease contracted if not at place of death? Belair Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hillis Burnard M D

10-6, 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cem DATE OF BURIAL. Oct 9 1924

20-UNDERTAKER. CHENOWETH & SON ADDRESS 2012 CHESTNUT AVE

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Philburn Balto,Md, mr. Wilmslow St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME...Elbridge K.Ludwig

(Residence in Baltimore: No...3816 Belle Avenue.....St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH

.....1 85?
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer): A. T. S.

9-BIRTHPLACE, (State or Country). Shrewsbury, Pa.

PARENTS.

10-NAME OF FATHER. Joshua Ludwig

11-BIRTHPLACE OF FATHER, (State or Country). United States

12-MAIDEN NAME OF MOTHER. Miss Klingfelter

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Ludwig
1454 W.King St.
(Address) York, Pa.

15-

Filed 10-7-1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 2nd 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Wound
Through Head
(Suicide)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Harrison M.D.
(Coroner.)

10-6 1924 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence York Pa.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Shrewsbury Pa	Oct 8 1924

20-UNDERTAKER.	ADDRESS
Harold B Cook	1023 N Eutaw St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90881

CERTIFICATE OF DEATH.

185 D 90881

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 221 N. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Aaron Willard Nolen

(a) Residence No. 221 N. Calhoun St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Louise Nolen

6-DATE OF BIRTH (month, day and year) May 28, 1844

7-AGE,	If LESS than 1 day,
80 yrs. 4 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Philadelphia (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, William Dorr Nolen

11-BIRTHPLACE OF FATHER (city or town) Philadelphia (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Margaret Chandler

13-BIRTHPLACE OF MOTHER (city or town) Wilmington (State or Country), Delaware

14- (Informant) Elizabeth C. Nolen

(Address) 221 N. Calhoun Street

15- Filed Oct 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10th 24 to October 5th 24, that I last saw h.m alive on October 5th 24, and that death occurred, on the date stated above, at 11.40 P.m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

Hypostatic Pneumonia

(Duration) yrs. mos. 1 ds.

Compound fracture of Leg

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. 25 ds.

18-Where was disease contracted if not at place of death? (over)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wallace A. Meyer M. D.

10-6-1924 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine cem	10-8 19 24

20-UNDERTAKER,	ADDRESS
Jos. B. Cook	1003 W. Baltimore St

Ed. Exact statement of OCCUPATION is very important. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Joseph's Hospital 23 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fiorina Fortuna

(a) Residence No. 917 N. 9th St., — Ward —
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Fortuna

6-DATE OF BIRTH (month, day and year) Nov. 8, 1891

7-AGE. 32 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Fermus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Katherine Fermus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Robert Fortuna
(Address) 917 N. 9th St.

15- Filed Oct 8 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924 to Oct 5, 1924 that I last saw h[illegible] alive on Oct 4, 1924 and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Oct 4, 1924 Cesarean Section

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic

(Signed) Thos. R. Galvin M. D.

, 19 (Address) 735 S. Monroe

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. — DATE OF BURIAL: Oct 8" 192[illegible]

20-UNDERTAKER: Joseph B. Cook — ADDRESS: No 3 N. Balto St.

T7

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90883

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D 90883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt. general Hospital

CITY OF BALTIMORE: (No. Rayner ave & Dukeland ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Thomas Ray

(a) RESIDENCE No. 503. W. Saratoga ST. 5t WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-3-1875

7 AGE	49 Years	Months 3	Days 4	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Saganaw mich.

PARENTS

10 NAME OF FATHER Thomas F Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jane Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Mrs Robert Harrison Wife

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

OCT 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1924, to Oct. 7 , 1924, that I last saw him alive on Oct 7. , 1924, and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncheal pneumonia.

10 (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cordiac Dilitation

5-10 hrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Geo Hubert Williamson M. D.

19 (Address) West Balto Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toledo Ohio

DATE OF BURIAL Oct 8 1924

20 UNDERTAKER Jahrens & Co

ADDRESS 1611 mad ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 244 S. Bouldin St., (Ward) 16

Registered No.....

2-FULL NAME Franklin Pierce Rhinehart

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 244 S Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) Elizabeth Rhinehart

6-DATE OF BIRTH (month, day and year) Jan 26 1853

7-AGE, 71 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Lens Maker

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Penn

PARENTS.

10-NAME OF FATHER, Adolf Rhinehart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Elizabeth Rhinehart (Address) 244 S. Bouldin

15- Filed OCT 7 - 1924 192 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 24, 19..., to Oct 6 24, 19..., that I last saw h.. alive on Oct 6 24, 19..., and that death occurred, on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Coad M. D

10/6, 1924 (Address) 413 E Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 10/8 19.24
20-UNDERTAKER, John J. Gahagan	ADDRESS 318 Dolphin St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90885

CERTIFICATE OF DEATH.

188-008

D 90885

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Davis

(a) RESIDENCE No. 16 S. Spring St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Davis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wagon Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Lester Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Ella Davis
(Address) 16 S Spring St

15 OCT 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
of Fall from Seat of Wagon
Accident

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia Hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) Jens W Lurbon, M. D.
(Coroner.)

Oct 7, 1924 (Address) York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Bayview Hospital

Former or usual residence 16 S Spring

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury

DATE OF BURIAL Oct 8 1924

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Georgie Berry.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90886

CERTIFICATE OF DEATH.

147 ✓ D 90886

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 N. Bond ST., 7 WARD)

2-FULL NAME Berry - Georgie.

(a) RESIDENCE NO. 629 N. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married.

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Abe Berry

6 DATE OF BIRTH (month, day, and year) June 6, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	39	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm J. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Golden Hill Md.

12 MAIDEN NAME OF MOTHER Julia Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ollie Harris (sister)

(Address) 142 Lanvale St

15 Filed OCT 8 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to Oct 7, 1924, that I last saw her alive on Oct 7, 1924, and that death occurred, on the date stated above, at 1 35 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus (?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Normal labor (parturition)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodberry cemetery

DATE OF BURIAL: Oct 10 1924

20 UNDERTAKER: Edward Bryor

ADDRESS 1631 Orleans st

MARRIAGE should be entirely supplied. AGE should be given in YEARS. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Infant Green

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

160 D 90887

D 90887

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Sterling ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unnamed

(a) RESIDENCE No. 727 Sterling ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5 minutes		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence Green

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Satterfield

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Lucy Satterfield
(Address) 1927 Hanover St

15 Filed OCT 8 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Congenital — poorly nourished — Malformation —
Mother gave history of rheumatism during pregnancy (duration) ..... yrs. ..... mos ..... ds.
CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collins, M. D.
(Coroner.)
10-7-1924 (Address) 528 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 8 1924
20 UNDERTAKER	ADDRESS 631
Edward Bryson	Orleans St

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 90888

CERTIFICATE OF DEATH.

74-001

REGISTERED No. B 90888

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N.Bradford ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Swailes

(a) RESIDENCE No. 514 B Bradford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Swailes

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Swailes (Daughter
(Address) 514 N.Bradford St. in-law

15 Filed OCT - 1924 ROBERT S. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. S. Kalen, M. D.

Oct 6/24, 192 (Address) 308 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burg cemetery — DATE OF BURIAL Oct 8 1924

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

90889

Hart

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90889

CERTIFICATE OF DEATH

1-PLACE OF DEATH West Maryland general Hospr. 124

REGISTERED NO.

CITY OF BALTIMORE: (No. Rayner Ave & Dukeland ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Hart

(a) RESIDENCE NO. 120 cedar Ave. ST., Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hart Widower

6 DATE OF BIRTH (month, day, and year) June 25. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Engr. 073

(b) General nature of industry, business, or establishment in which employed (or employer) Penn. Railroad

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francis Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maland.

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Theatis J Hart

(Address) 128 Cedar Ave

15 Filed OCT 8 - 1924 ROBT. F. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/24 1924

17

I HEREBY CERTIFY, That I attended deceased from 10/6/24, 1924, to 10/6/24, 1924,

that I last saw h alive on 10/6/24, 1924,

and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis. Chronic myocarditis.

4-6 (duration) years. — mos. — ds.

CONTRIBUTORY (Secondary) cardiac dilatation

2-4 hrs (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? no.

What test confirmed diagnosis? clinical.

(Signed) Jos Hurst Wilkinson, M. D.

19 (Address) 1 West Balto Sec Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Johns. Waverly

DATE OF BURIAL Oct 9 1924

20 UNDERTAKER Wm Cook

ADDRESS 1302 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90890

CERTIFICATE OF DEATH.

24 31

D 90890

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Frock

(a) Residence No. 221 Norfolk st. Wolfe St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1900

7-AGE. 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Wood lather

(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer. Unknown

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Frock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Alice Fuss

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Hospital Records

(Address) M.T.H.

Filed Oct 6 1924 ROBERT A. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 5. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1924 to Oct. 5, 1924 that I last saw him alive on Oct. 5, 1924 and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. F. White, M. D.

10-6, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL, Oct. 7, 1924

20-UNDERTAKER. H. Harder & Sons — ADDRESS 1710 Eliot St.

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90891

CERTIFICATE OF DEATH.

170 D 90891

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph 's Hospital ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Jacob

(Residence in Baltimore: No. 1114 Montepelier ..... St.: yrs. Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH, ... Jan-1st-1875 ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
49 yrs. 9 mos. 5 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Post Office Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... NG

9-BIRTHPLACE, (State or Country),
Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Jacob

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth M. Wolf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Mrs. Charles E. Murphy (sister)

(Address)...1114 Mantapelier.....

15- OCT 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct 6/24 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) inquiry ..... find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot thru rt temple-suicide

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Illhealth was cause .....

Tuberculosis (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

10/7/24 191... (Address)..5pi E. north Av....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	10- 9 ....., 1924

20-UNDERTAKER	ADDRESS
C.F.Evans & Son, Inc.	118 W. Mt Royal Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90892 ✓ D 90892

D 90892

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. In street car. Penna Ave & Franklin Sts. WARD)

2-FULL NAME Annie Reid

(a) RESIDENCE No. 1002 N. Carrollton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of James W. Reid

6 DATE OF BIRTH (month, day, and year) about 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alex. Shell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James W. Reid
(Address) 1002 ~~Carrollton Ave~~

15 OCT 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquiry~~ (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Oct. 7, 1924 (Address) 2702 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	10/8/1924
20 UNDERTAKER	ADDRESS
Mrs. Helen A. Holland	1601 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90893

CERTIFICATE OF DEATH.

179 D 90893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelina Bucchere

(a) RESIDENCE No. 916 Harford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) 10/16/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Tomas Bucchere

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Anello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Tomas Bucchere
(Address) 916 Harford Ave

15 OCT 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental- Burns over neck & body- Clothing caught fire while playing with matches

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Baker, M. D.
(Coroner.)

10/8/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 10/8 1924

20 UNDERTAKER George F Ruth

ADDRESS 1785 Harford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90894

CERTIFICATE OF DEATH.

D 90894

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Mens Home St., 19 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank N. Beaver

(a) Residence No. 1400 W Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 4 1859

7-AGE, 65 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, George Beaver

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Anna Park

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Mrs L Blanche Fisher

(Address) Matron

15- OCT 8 - 1924 ROBT. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 7, 1924.

17- I HEREBY CERTIFY, That I attended deceased from May, 19 24, to Oct 7, 19 24,

that I last saw h alive on Oct 6, 19 24,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Oct 8, 19 24 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Oct 9, 19 24

20-UNDERTAKER, George J Smith — ADDRESS 1532 Hollins St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3001 Ellerslie Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith May Biggs

(a) Residence No. 3001 Ellerslie Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 28 1917

7-AGE, 7 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Edgar S Biggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Ethel McCauley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Edgar S Biggs

(Address) 3001 Ellerslie Ave

15- Filed OCT 8 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 7 1924

17- I HEREBY CERTIFY, That I attended deceased from October 7th 1924 to Oct. 7th 1924.

that I last saw her alive on Oct. 7th 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cultures

(Signed) George Jongeward M.D.

10/8/24 19 (Address) 401 E 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Oct E, 1924

DATE OF BURIAL

20-UNDERTAKER, Wm Cook

ADDRESS 502 E Fayette

Burial Permit Issued

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90896

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 90896

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Johns Girls School

REGISTERED No.

CITY OF BALTIMORE: (No. 908 Valley St ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister Cecelia (Cecelia McManus)

(a) RESIDENCE No. 908 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sister of Charity
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Charles McManus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McHaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Aloysius
(Address) 908 Valley St

15 [illegible]

OCT 8 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thrombosis Cerebri

several yrs (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Cain, M. D. (Coroner.)

10-7 1924 (Address) 508 E Hunter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Oct 9 1924

20 UNDERTAKER H. C. Wiedefeld

ADDRESS 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90897

CERTIFICATE OF DEATH.

90 D 90897

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Edmondson Ave ST. 19 WARD)

2-FULL NAME Auguste Laube

(a) RESIDENCE No. 1515 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 49 yrs. mos. ds. How long in U. S., if of foreign birth about 49 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: ~~HUSBAND of~~ Henry Laube Sr

6 DATE OF BIRTH (month, day, and year): Dec 4 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Laube Sr (Address) 515 Edmondson Ave

15 OCT 8 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1924, to Oct 6, 1924, that I last saw her alive on Oct 6, 1924 and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Myocarditis

(duration) Over 1 mos. 4 ds.

CONTRIBUTORY (Secondary): None (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Laube, M.D.

Oct 6. 1924 (Address) 1203 W. Fayette St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 9th 1924
20 UNDERTAKER: Philip Seewald & Son	ADDRESS: 1825 N. Forth ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90898

CERTIFICATE OF DEATH.

15 33 D 90898

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

No. 547 Presstman ST. 15 WARD)

2-FULL NAME Robert A. Chase

(a) RESIDENCE. No. 547 Presstman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marguerite B Chase

6 DATE OF BIRTH (month, day, and year): Sept. 27. 1865

7 AGE: Years 59 Months 0 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Porter

(c) Name of employer: B.T.C.

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: John W. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md.

12 MAIDEN NAME OF MOTHER: Emma Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mortunsburg W. Va.

14 Informant: W. H. Wright

(Address): 709 Presstman St

15 Filed OCT 8 - 1924 ROBERT R. KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1924, to Oct 7, 1924, that I last saw h— alive on Oct 6, 1924, and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enterolis Tuberculosis.

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary): None

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Wright, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Working Mens Department Cem. Frederick, Md

DATE OF BURIAL: Oct. 10 1924

20 UNDERTAKER: John H. Toadvine

ADDRESS 1027 Hand St Alley

PENALTY OF PERJURY in plain terms, as that is the penalty for making a false statement in this certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90899

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Hawthorn Road, Roland Park 15 (WARD)

2-FULL NAME Jane E. Kelly

(a) RESIDENCE No. 1610 N. Fulton Avenue St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 35 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	55	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. John F. Everhart
(Address) 3307 Guilford Avenue

15 Filed ..... 192 ..... Registrar

8 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey, M. D.
(Coroner.)

6A 7, 1924 (Address) 3602 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 10/9 1924

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90900 ~~D 90900~~ 65-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3901 Kate Ave St., 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin W. King

(a) Residence No. 3901 Kate Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elvira L. King

6-DATE OF BIRTH (month, day and year) Feb 14 1851

7-AGE, 73 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter 063

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. L. King.

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Stansbury

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md

14-

(Informant) Mrs. Elvira L. King

(Address) 3901 Kate Ave

15-

FILED 1924 Robert P. Harrison, 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 7th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to Oct 6, 1924,

that I last saw h. ~~alive~~ on Oct 6, 1924,

and that death occurred, on the date stated above, at 3:50 A. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & Examination of resected gland

(Signed) A. C. Bernheim, M. D.

(Address) 1923 N. Eutaw Pl. Balto. Md. 1924

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodmont Cem. DATE OF BURIAL, Oct 10th 1924

20-UNDERTAKER, J. Edward Lee ADDRESS, 1923 N. Eutaw Pl. Balto. Md.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T8

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90901

CERTIFICATE OF DEATH.

D 90901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Calhoun St ST., 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Evans

(a) RESIDENCE NO. 1125 Calhoun St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1125 Calhoun St (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Dorthy Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mother
(Address) 1125 Calhoun St.

15 Filed 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CT 8

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-1924

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1924, to 10-6, 1924, that I last saw her alive on 10-6, 1924, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Bronchs pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Malnutrition & rickets

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank P. Saunders, M. D.

, 19 (Address) 1125 E. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Oct 9 1924

20 UNDERTAKER: Mr S Jas. H. Dennis per T. E Nelson — ADDRESS: 1933 Presstman St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S diagnosis may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Frank Waclawski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90902

CERTIFICATE OF DEATH.

159

D 90902

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3235 Register ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Waclawski

(a) RESIDENCE NO. 3235 Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 Mos. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John Waclawski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalene Gizel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant John Waclawski
(Address) 3235 Register St

15 Filed OCT 8 1924 Robert P. [illegible], Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pending Inquiry
Fracture of skull

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

(Signed) James H. Fulton, M. D.
(Coroner.)

Oct 8, 1924 (Address) Fort Clarke

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Oct [illegible] 1924
20 UNDERTAKER M. F. Sadowski	ADDRESS 1055 E. [illegible]

Burial Permit Issued

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 90903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90903

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Turner

(a) RESIDENCE NO. Mercy Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mercy Hospital (Address)

15 Sept. 19 Robert P. Harrison, Registrar

T8 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8/24

17

I HEREBY CERTIFY, That I attended deceased from 10/3/24, 19..., to 10/8/24 19...

that I last saw h alive on 10/8/24

and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Bowel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	10/9/24

20 UNDERTAKER Lloyd Tinley Fulton & Smythe ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 90904

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Apt #43 Hilton Court Apts ST.: 15 WARD)

2-FULL NAME Mary Avondale Norris

(a) RESIDENCE. No. Apt #43 Hilton Court Apts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. D. Norris

6 DATE OF BIRTH (month, day, and year) Nov 18 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Milburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mount Carmel Carmby Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mount Gomery County Md.

14 Informant J. H. Hobbs

(Address) Apt 43 Hilton Court Apt.

15 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to Oct 7, 1924, that I last saw h[illegible] alive on Oct 6, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Edeno carcinoma

Visceral Carcinomatosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Clinical findings

(Signed) Geo R. Wiseley, M. D.

. 19 (Address) 1330 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leeds Mound	Oct 9. 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T8

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90905

CERTIFICATE OF DEATH. X 188-D 90905

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Harry Orenstein

(a) RESIDENCE NO. 325 E. 21st. St New York City WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Few hours yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Sept 19/1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New York City
(State or country)

PARENTS

10 NAME OF FATHER Henry Orenstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Ethel Goldman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Leo Orenstein
(Address) 325 E.21st St. Newyork

15 FILED 8-1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- Fractured rt leg &lt fore-arm- burnsof both legs & face,
Automobile Accident, oct 6/24
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wales (Coroner), M. D.
10/9/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N.Y.	Oct 8 1924
20 UNDERTAKER Richard F. Curley	ADDRESS 1108 Guilford

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 90906

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1628 E Lafayette ave St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margaret Spencer

(a) Residence No..... 1628 E Lafayette ave St., ... Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh D. Spencer

6-DATE OF BIRTH (month, day and year) Feby 27th 1853

7-AGE. 71 yrs. 7 mos. 10 ds.

If LESS than 1 day, ...hrs. or, ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, William Bode

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Magduline Meintze

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Samuel D. Spencer

(Address) Harrisburg Pa

15- ..... 19..

ROBERT R. KRAUTER, Registrar.

OCT 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 7th 1924

I HEREBY CERTIFY, That I attended deceased from Oct 2 1924, to Oct 7 1924, that I last saw h[illegible] alive on Oct 7 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J E Bennebeck M. D.

(Address) 1531 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park Cem	Oct 11th, 19 24
20-UNDERTAKER,	ADDRESS
George Schilling & Sons	1120 E Monument st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Joseph . Kopczynski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

90907

D 90907

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced Dead at

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 3 WARD)

2-FULL NAME Joseph Kopczynski

(a) RESIDENCE No 1407 Easton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) May 3 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer Con Co

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stephen Kopczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonia Stankiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Elizabeth Kopczynski
(Address) 2601 Tait Ave

15 OCT 9 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Hi death on the day stated ahove.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage (duration) Sudden yrs. mos. ds.

(Signed) James M Fenton (Coroner.) M. D.

Oct 8, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct. 10 1924
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank st

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 109 D 90908

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Ernest E. Parks

(a) RESIDENCE NO. Tangier Va. ST., ... WARD Tangier, Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Ellis Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maggie Whalley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ernest Brundallen
(Address) Pocomoke City Md

OCT 9 - 1924

ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W R Grinnell M. D.
(Coroner.)

Oct 8, 1924 (Address) 127 W Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tangier Va DATE OF BURIAL Oct 9 1924

20 UNDERTAKER J W Pruett for ADDRESS Norfolk

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

68 Raspe Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90909

D 90909

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. Mount St. ST., W WARD)

2-FULL NAME Robert Herman Collier

(a) RESIDENCE No. 68 Raspe Ave ST., ... WARD 11

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman Otto Collier

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(h) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) City Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Herman Otto Collier

11 BIRTHPLACE OF FATHER (city or town) Buffalo.
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary Mary Kramer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Herman O. Collier
(Address) 68 Raspe Ave.

15 Filed OCT 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1924. to Oct 8th , 1924 ,
that I last saw him alive on Oct 7 , 1924 ,
and that death occurred, on the date stated above, at 2.45 A m.
The CAUSE OF DEATH* was as follows:
Congenital Atelectasis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) L. K. Cody, M. D.

(Address) 1735 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct. 9 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90910

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1. Holley ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Masich

(a) Residence No. 1. Holley ave. Hamilton St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Henry Masich

6-DATE OF BIRTH (month, day and year) 4/13/1850

7-AGE. 74 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Louis Russell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sedlick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Henry J Masich Jr

(Address) 791 Gilmor St

15-

Filed OCT 9 - 1924 192.. ROBERT R. KEHNERT Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/7/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 20th, 19 24 to Oct 7th, 19 24

that I last saw h[er] alive on Oct 7th, 19 24

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J D Horen, M. D.

Oct 8th, 192 4 (Address) 157 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem

DATE OF BURIAL. Oct 10 192 4

20-UNDERTAKER, John Merrick

ADDRESS 2008 Aliceanna

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 90911 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90911

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3122 Fait Av (ST.) 1 (WARD)

2-FULL NAME Wm Paul Smith

(a) RESIDENCE. No. 3122 Fait Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at school

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer —

9 BIRTHPLACE, (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul H Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ada M Bachelor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Paul H Smith
(Address) 3122 Fait Ave

Filed OCT 9 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7- 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-1-24. 19 . to 10-7- . 1924
that I last saw him alive on 10-7 1924
and that death occurred, on the date stated above, at 9 11 0 m.
The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) By DW Cleary, M. D.

10/7 1924 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Oct 10 1924
20 UNDERTAKER John Meerist	ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90912

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 Claremont ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Piccione

(a) RESIDENCE. NO. 3906 Claremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct. 11th 1923

7 AGE — Years: .. Months: 11 Days: 26 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Carmine Piccone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosie Bracaglene

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Carmine Piccone
(Address) 3906 Clairmont Ave

15 Filed ..., 19... OCT 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/ 1924

17 I HEREBY CERTIFY, That I attended deceased from October 3, 1924, to Oct. 7, 1924, that I last saw h[im] alive on Oct. 7, 1924, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ... yrs. 1½ mos. ... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia & Ileo-Colitis (duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani, M. D.

, 19 (Address) 2942 Effaylee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Oct 9 1924

20 UNDERTAKER: John Ellrich

ADDRESS: 2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90913

CERTIFICATE OF DEATH.

74001 D 90913

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2425 Linden Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldy Hyman

(a) Residence No. 2425 Linden Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Kopel Hyman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 72 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Ben H. Hyman

(Address) 2425 Linden Ave

13- OCT 9 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Oct 8, 1924

that I last saw her alive on Oct 7, 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension (Duration) ... yrs. Several yrs mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Southern Md. DATE OF BURIAL, Oct 10 19 24

20-UNDERTAKER Sol Simson ADDRESS 1027 E Balto St

10/10

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90914

CERTIFICATE OF DEATH.

45

REGISTERED NO. D 90914

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St + Rutland Ave. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meldred Kartman

(a) RESIDENCE NO. 3700 Dorchester ST., Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isador F. Kartman

6 DATE OF BIRTH (month, day, and year) July 29, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Ephraim M. Cohen

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Judith Spingfeller

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Isador Kartman

(Address) 3700 Dorchester Rd

OCT 9 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/30, 1924, to 10/7, 1924, that I last saw her alive on 10/7, 1924, and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Pulmonary edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/31

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Philip Jacobson, M. D.

, 19 (Address) Helmar Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 10/10/1924

20 UNDERTAKER David Sondheim ADDRESS 15-20 W Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90915

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N Edew ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Thompson

(a) RESIDENCE NO. 210 N Edew ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) May 2 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Gilmor

11 BIRTHPLACE OF FATHER (city or town) S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Missouri Thompson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Missouri Thompson (Mother)
(Address) 210 N. Edew St

15 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 8, 1924, that I last saw him alive on Oct 8, 1924, and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Acute Gastro - Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTOR (Secondary) (Indiscretion of diet)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

Oct 9, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Oct. 10 1924
20 UNDERTAKER Wm J. G. Locke	ADDRESS 1302 Jefferson

T9 - 1924

MEDICAL CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should bear in mind that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90916

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2611 West Fayette St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Levering N. Reier

(a) Residence No. 2611 West Fayette St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11f yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine H. Reier

6-DATE OF BIRTH (month, day and year) Sept. 6, 1875

7-AGE. 49 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Andrew Reier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, E. Marcelline Newbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs. Catherine H. Reier

(Address) 2611 W. Fayette street

15- Filed Oct 9 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12, 19 23 to Oct. 8, 19 24, that I last saw him alive on Oct. 8/24, 19....., and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. V. Coolahan, M. D.

10-9. 19 24 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct 11th, 1924

20-UNDERTAKER.	ADDRESS
Joseph F. Cook	1003 W. Balto st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90917

CERTIFICATE OF DEATH.

D 90917

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2858 W. North Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline E. Nelson

(a) Residence No. 2858 W. North Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 16, 1842

7-AGE. 82 yrs. 8 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Richard Nelson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Delilah Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Richard Nelson

(Address) 2858 W. North Avenue

15-

Filed Robert P. Harrison, Registrar.

T9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 5 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 20" 1924 to Oct 8th 1924

that I last saw h[illegible] alive on Oct 7th 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation & Stenosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

(Signed) Herbert E. Zapp, M. D

Oct 9, 1924 (Address) 3048 Ft. Worth Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Newlywd Baptist Cemetery DATE OF BURIAL. Oct 10, 1924

20-UNDERTAKER. E. LeRoy Stiffler ADDRESS 1125 E. North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90918

CERTIFICATE OF DEATH.

185 D 90918

1-PLACE OF DEATH West Baltimore general Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Raynor Ave & Bushland ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs. Mary E Cho

(a) RESIDENCE NO. 531 west 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widowed.

6 DATE OF BIRTH (month, day, and year) July 30-1849

7 AGE	75 Years	Months 2	Days 8	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) maryland.

PARENTS

10 NAME OF FATHER george W. Rodes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) maryland.

12 MAIDEN NAME OF MOTHER mary bell smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) maryland

14 Informant Odin Echo. (Address) 531 Baltimore St. W. Mrs.

15 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 9 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8/ 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1924, to Oct. 8, 1924, that I last saw him alive on 10/8/, 1924, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

fracture of Rt femur

fracture of Rt Radius & ulnar.

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? no. clinical

What test confirmed diagnosis?

(Signed) Jos. Hulst Williamson, M. D.

, 19 (Address) West Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 10 1924

20 UNDERTAKER George L. Schwab

ADDRESS 610 Cook Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME and ADDRESS must be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90919

D 90919

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 70 WARD)

2-FULL NAME Joseph Shaw

(a) RESIDENCE NO. 347 Southhill ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 3-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Shaw

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Marie Mooney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 9 1924, 19 Robert P. Haffner, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Oct 8, 1924, that I last saw him alive on Oct 8, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio
Acute primary pneumonia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? In hospital

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.

10/9, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mt — DATE OF BURIAL Oct 10 1924

20 UNDERTAKER Harry H. Witzke — ADDRESS 1538 W. Lombard St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90920

CERTIFICATE OF DEATH.

D 90920

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 Park Ave St., 14 Ward) Registered No. 46

2-FULL NAME Martha Badders St. Martin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1733 Park Ave St., Ward. Resident.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 1 ds. How long in U. S., If of foreign birth? 62 yrs. 10 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. St. Martin

6-DATE OF BIRTH (month, day and year) Dec-8-1861

7-AGE,	If LESS than 1 day,
62 yrs. 10 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John T. Badders

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Edith Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs. Jos. H. St. Martin Jr.

(Address) 1733 Park Ave.

15- OCT 10 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov., 19.23, to Oct 8, 19.24,

that I last saw her alive on Oct 9, 19.24,

and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus
with abdominal metastases

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of July 1924

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. F. Kretzer, M. D.

Oct 10, 1924 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loman Cemetery	Oct 10, 1924
20-UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPA tant. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 90921

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 4 WARD)

2-FULL NAME Mr. Charles C. Carroll

(a) RESIDENCE No. 1526 Argyle ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Carroll (?)

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh, N. Carolina

PARENTS

10 NAME OF FATHER Ruffin Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N. Carolina

12 MAIDEN NAME OF MOTHER Charlotte (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh N.C.

14 Informant Mr. Chas. C. Carroll
(Address) 1526 Argyle St.

15 Filed ROBERT R. KRAUTER, Burial Permit Clerk

OCT 1 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 — 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 2 .1924. to Oct. 7 .1924.
that I last saw him alive on Oct. 7 .1924.
and that death occurred, on the date stated above, at 9:40 P.m.

The CAUSE OF DEATH* was as follows:

Ulcerative colitis — 8 weeks
Chronic Nephritis } 5-6 years
Myocarditis Chronic }
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas C Templeman, M. D.

, 19 (Address) My God Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	10-11-24
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Pine.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90922

38 D 90922

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals, 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Brown

(a) Residence No. 216 W. Chase St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1893

7-AGE. 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Virginia (State or Country),

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know

11- (Informant) Municipal Hospital Records

(Address)

15-

Filed 192 ROBERT R. KRAUTER Registrar.

OCT 10 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-6-24

17- I HEREBY CERTIFY, That I attended deceased from 9-13 19 24 to 10-6 19 24

that I last saw h[illegible] alive on 10-6 19 24

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, C. N. S.

Syphilis (General Paresis)

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude C. Howe M. D.

10-8, 19 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL 19
Woodlawn	10/10/24
20-UNDERTAKER.	ADDRESS
Daniel Easton Funeral	716

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90923

CERTIFICATE OF DEATH.

31 D 90923

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Woesche ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Taylor

(a) RESIDENCE No. 729 Woesche ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Edward Taylor

6 DATE OF BIRTH (month, day, and year) Dec. 25- 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic servant

(b) General nature of industry, business, or establishment in which employed (or employer) General house work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. B. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sylvia Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Jane Reed

(Address) 729 Woesche St.

15 Filed OCT 10 1924 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13- , 1924 , to Oct. 8- , 1924 , that I last saw her alive on Oct. 8- , 1924 , and that death occurred, on the date stated above, at 9-45 a. m.

The CAUSE OF DEATH* was as follows:

Sub-acute gastritis following acute congestion of liver.

(duration) — yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary) Acute hepatic congestion

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. T. McCarthy M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ottman Whf. Lancaster Co. Va.

DATE OF BURIAL Oct 9 19

20 UNDERTAKER Edward D. Hensley

ADDRESS J. W. Biddle

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90924

D 90924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 823 Harlem Ave St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Munyon V. Rawlings

(a) RESIDENCE NO. 823 Harlem Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Wm M. Rawlings

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Emma Sattler

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Wm M. Rawlings

(Address) 823 Harlem Ave

15 Filed OCT 10 1924 ROBERT N. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 7, 1924.

that I last saw h[illegible] alive on Oct 7, 1924.

and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Edema of Glottis

Caused by Foreign body

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. V. Averill M. D.

1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Oct 9 1924

20 UNDERTAKER Samuel Stansbury

ADDRESS W Baltimore

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90925

CERTIFICATE OF DEATH.

74-001

D 90925

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Hope st ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther L. Schumaker

(a) RESIDENCE No. 1819 Hope st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mrs G. Schumaker

6 DATE OF BIRTH (month, day, and year) July 17, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McCaul Stable

9 BIRTHPLACE (city or town) (State or country) Virginia Va.

PARENTS

10 NAME OF FATHER Luther Schumaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia W.

12 MAIDEN NAME OF MOTHER G. Riffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Robinson

(Address) 1819 Hope st.

15 Filed OCT 10 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1924, to Oct 7, 1924, that I last saw him alive on Oct 7, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C O Carman, M. D.

10-10-1924 (Address) 1701 N Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL United Rigde Cemetery

DATE OF BURIAL 10 10 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90926

Registered No. D 90926

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Davis

(a) Residence No. 1117 Thompson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Pat Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Martha Brett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed OCT 10 1924 ROSE R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5, 19 24 to Oct. 5, 19 24

that I last saw him alive on Oct. 5, 19 24,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous laryngitis

Lues

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Richard Shoe, M. D.

10-6-, 1924 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 19

20-UNDERTAKER. ADDRESS

STATE OF MARYLAND ... State Board of Health.

Should be correctly supplied, as it may be properly classified. Exact statement of OCCUPATION is very important. See instructions in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

90927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Hospital St. ..... WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris M. White

(a) RESIDENCE NO. 532 Annapolis Ave (or Brooklyn) St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15 1922.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2	3	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Howard A White

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Ella M Berry

13 BIRTHPLACE OF MOTHER (city or town) Charles Co
(State or country) Md

14 Informant Mr Howard A White
(Address) 532 Annapolis Ave

15 OCT 10 1924 ROBERT R. KRAUTER, Registrar

Vital Records Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound Injury brain - shot by her father

5-4 days, 23-days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

(Signed) W. T. Foley, M. D.
(Coroner.)

Oct 9, 1924 (Address) 10 Bay Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 23-days

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? 532 Annapolis Ave.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 10 1924
20 UNDERTAKER John F Denny	ADDRESS 915 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

90928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90928

1-PLACE OF DEATH

City of BALTIMORE: (No. 237 Patapsco Ave St., Brooklyn 7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Grieneisen

(a) Residence No. 237 Patapsco Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Grieneisen

6-DATE OF BIRTH (month, day and year) Sep 3 1833

7-AGE 91 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER Ernest Grieneisen

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Catherine Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Mrs Fannie E Pennsbury

(Address) Brooklyn Md

15- OCT 10 1924 ROBERT R. KRAUSE Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9/924

17- I HEREBY CERTIFY, That I attended deceased from about 24 1924 to Oct 9 1924

that I last saw him alive on Oct 9 1924

and that death occurred, on the date stated above, at 3 20 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos F Brooke M. D.

Oct 9 1924 (Address) Brooklyn Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 11 1924
20-UNDERTAKER	ADDRESS
John F Denny	715 Light St

Should be carefully supplied. Also should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90929

CERTIFICATE OF DEATH.

90 D 90929

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 Light St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. O'Hara

(a) Residence No. 1526 Light St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas J. O'Hara

6-DATE OF BIRTH (month, day and year): Sept. 28 1866

7-AGE: 58 yrs. 0 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: John H. Foss

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Margaret A. Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant): Thomas J. O'Hara

(Address): 1526 Light St.

15- Filed Oct 10 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 to 23 to Oct 8 19 24

that I last saw her alive on Oct 8 19 24

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Duration: yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Epithelioma

Duration: yrs. 1 mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D

(Address) 1320 E Fort

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem.	Oct. 11 1924
20-UNDERTAKER. J. Fenw McCully	ADDRESS 130 E. Fort

Should be carefully examined as to correctness and fully executed. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Entries should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90930

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST.: 22/122 WARD)

2-FULL NAME Wm. S. Coleman

(a) RESIDENCE. NO. 519 Sharp ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer F. J. Sinnaman Co
Fremont & Pascal sts

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant .....
(Address) .....

15 Filed OCT 10 1924 ROBERT R. KRAUTER, Registrar
THE MORGUE Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1924, to Oct 8, 1924
that I last saw h alive on Oct 8, 1924
and that death occurred, on the date stated above, at 4. a. m.
The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal Ascites

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. J. Conrey M. D.

. 19 (Address) Vol. of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem 10/24/24	10 19 1924
20 UNDERTAKER	ADDRESS
For Wm E. WOODALL	

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9-002

D 90931

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Bridget Conway.

(a) Residence No. Preston & Valley Sts. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (Write the word.) Widow

5a-~~If married~~, widowed, ~~or divorced~~ HUSBAND ~~WIFE~~ of (or) Dominick Conway.

6-DATE OF BIRTH (month, day and year) 1851

7-AGE, ...73...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Stanley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant)...Sister Florence.....

(Address)...Preston & Valley.....

15-

FILED OCT 10 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9/24

17- I HEREBY CERTIFY, That I attended deceased from no record, 19..., to..., 19...,

that I last saw her alive on Oct 5, 1924,

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. A. Warner, M. D.

Oct 9, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 10/10/24, 19....
Holy Cross - Lees -	
20-UNDERTAKER, J. E. Wedefeld & Co	ADDRESS Greenmount Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90932

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1049 Greenmount Ave Ward) 10

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert Curville

(a) Residence No.... 1049 Greenmount Ave Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 12 - 1853

7-AGE, 71 yrs. 1 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Samuel Curville

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Charity Kitchcock

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14-

(Informant) Sarah Curville

(Address) 1049 Greenmount Ave

15-

Filed OCT 10 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1924 to Oct 8th 1924

that I last saw him alive on Oct 8th 1924

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Caused by Hypertension

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) D. S. Long, M. D.

Oct 9, 1924 (Address) 1507 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	Oct 10, 1924
20-UNDERTAKER.	ADDRESS
H. C. Windfeld	914 Greenmount Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90933

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N. Port ST.: 8 WARD)

2-FULL NAME Elizabeth Schaaf

(a) RESIDENCE. No. 1630 N. Port ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard Schaaf

6 DATE OF BIRTH (month, day, and year) Aug. 4. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Thomas Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Agnes Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Agnes Frost mother
(Address) 1630 N. Port St.

Filed OCT 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from some time in 1922, to Oct. 7th 1924, that I last saw h[illegible] alive on Oct. 7th 1924, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach secondary to

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of both Breasts

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? One Breast removed 2 yrs ago the other 6 mos. ago

Did an operation precede death?

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Sandrock, M. D.

Aug. 1924 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 11th 1924
20 UNDERTAKER Philip Hovig	ADDRESS 2016 Orleans St

CAUSE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90934

CERTIFICATE OF DEATH.

165

REGISTERED NO. D 90934

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Schroeder St ST., 18 WARD)

2-FULL NAME Wilbert Brown

(a) RESIDENCE NO. 114 N Schroeder St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colo	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6, 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	~~0000~~		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Molder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ezarick Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Florence Brown
(Address) 306 N. Mount St.

OCT 10 1924

ROBERT P. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poison from Drinking Embalming Fluid

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gonsch, M. D.
(Coroner.)

10-9, 1924 (Address) 117 N Dakota

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Oct. 11 1924
20 UNDERTAKER Eugene Waters	ADDRESS 246 W. Hoffman St.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90935

CERTIFICATE OF DEATH.

90 D 90935

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2420 E. Lafayette Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Thomas McDonald

(a) RESIDENCE NO. 2420 E. Lafayette Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte M. Elizabeth McDonald

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Wm. George G. McDonald

(Address) 2420 E Lafayette Ave

15 OCT 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10 1924

17 I HEREBY CERTIFY, That I attended deceased from October 1 1924, to October 10 1924, that I last saw him alive on October 8 1924, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Old age and general debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus & Thrombosis of the Heart (duration) yrs. One mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Thomas McDonald M. D.

Oct 10 1924 (Address) 1617 Goucher Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 13 1924
20 UNDERTAKER Henry Woeck Son	ADDRESS 1801 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Ida Buppert

Spec.—1-10-21—M&T—1500 Blks.

D 90936

HEALTH DEPARTMENT—CITY OF BALTIMORE

138

D 90936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Gen Hosp'l ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Buppert.

(a) RESIDENCE NO. 3219 E Baltimore ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Buppert

6 DATE OF BIRTH (month, day, and year) Sept 22, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hwife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Albert Faber

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Agusta Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Ida Buppert
(Address) 3219 E. Baltimore

Filed OCT 10 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1924, to Oct 7, 1924,

that I last saw her alive on Oct 7, 1924,

and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Tubo Ovarian Abscess

Cardiac Weakness & Anemia

Exhaustion —

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Endocarditis & Colitis

Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 29, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mt Gen Hospitals, M. D.

, 19 (Address) Mt Gen Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Oct 10, 1924

20 UNDERTAKER John A. Moran — ADDRESS 3000 Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 90937

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Morton

(a) RESIDENCE No. 1439 E. Baltoa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1882 (Inquiry)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jack Lewis
(Address) 1439 E. Baltoa St.

15 OCT 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Inter. Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

Oct. 10, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Hamlet N. C.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamlet N. Carolina	10-10 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90938 ✓ D 90938

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1622 Division St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah C. Meredith

(a) Residence No. 1622 Division St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Meredith

6-DATE OF BIRTH (month, day and year) Sept. 10-1859

7-AGE. 65 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Perry Chew

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) John A. Meredith

(Address) 1622 Division St.

15- OCT 10 1924 ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 10/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 19 24 to Oct 10 19 24

that I last saw h. alive on Oct 9 19 24

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchym. Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Uranalysis

(Signed) H. S. McCarty, M. D.

10/10. 19 24 (Address) 2000 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 10/13/1924
Mt. Auburn	
20-UNDERTAKER. Geo. J. A. Gibson	ADDRESS 1705 Druid Hill

Should be carefully supplied. AGE should be stated EXACTLY. Physicians filling this CAUSE OF DEATH should be classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90939

CERTIFICATE OF DEATH.

129 D 90939

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 W Saratoga ST., 4 WARD)

2-FULL NAME Isaac Robinson

(a) RESIDENCE NO. 644 W Saratoga ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE): Maggie Robinson

6 DATE OF BIRTH (month, day, and year): ? ? 1865

7 AGE: Years 59 | Months ? | Days ? | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farm hand
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wally Robinson
(Address) 1 Ely Leader Hall St.

15 Filed OCT 1 0 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 8, 1924, that I last saw h.. alive on Oct 8, 1924, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Howell M. D.

19 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Rest Towson — DATE OF BURIAL: 10/11/24

20 UNDERTAKER: Helen A Holland — ADDRESS: 1631 Druid Hill Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90940

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Essex ST., 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorota Krynski

(a) RESIDENCE No. 2232 Essex ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Ballinger

(State or country) Poland

PARENTS

10 NAME OF FATHER James Kraski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Jenski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant James Kraski

(Address) 2232 Essex St

OCT 10 1924

ROBERT R. KRAUTER, Registrar

Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9 1924

17

I HEREBY CERTIFY, That I attended deceased from 10/8, 1924, to 10/9, 1924,

that I last saw her alive on 10/9, 1924,

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis, & Collapse

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia & Asthenia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos A Bullock M. D.

10/10/1924 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Oct 11, 24
20 UNDERTAKER	ADDRESS
J. W. Ozazeus	925 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90941

CERTIFICATE OF DEATH.

D 90941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stevano Litto

(a) RESIDENCE NO. St Vincents Inf Asylum ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 1 0 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 9, 1924, that I last saw him alive on Oct 9, 1924, and that death occurred, on the date stated above, at 5:55 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea and vomiting

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter L. Stewart, M. D.

10/10 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocahontas Va — DATE OF BURIAL 10/10 1924

20 UNDERTAKER S. Kinston & Bro — ADDRESS 1127 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

175 146 D 90942 — CERTIFICATE OF DEATH. — X 100-001 D 90942

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zacheus Gill

(a) RESIDENCE NO. Lancaster ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER W. T. Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lavia Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 10 1924 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 9, 1924.

that I last saw h alive on Oct 9, 1924.

and that death occurred, on the date stated above, at 2054 m.

The CAUSE OF DEATH* was as follows:

Streptococcus infection leg
Pneumonia
Septicemia ?

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)
Pneumonia (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) Thos Harrold, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Va — DATE OF BURIAL 10-10 1924

20 UNDERTAKER E & B Hale — ADDRESS 115 E Wash St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90943

CERTIFICATE OF DEATH.

66 D 90943

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Sharp St. ST., 22 WARD)

2-FULL NAME Charles Thomas. (C).

(a) RESIDENCE NO. 317 S. Sharp St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Neal Spann (C).
(Address) 317 S. Sharp St.

15 Filed OCT 1 0 1924 Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Oct. 9, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Auth Cemetery	Oct 10 1924
20 UNDERTAKER	ADDRESS
Jno. F. & H. Hooper	406 W. Conway st

Spec.—1-10-21—M&T—1500 Bks.

D 90944

175 3344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 31 D 90944

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Gross

(a) RESIDENCE No. 914 Calhoun St. ST., WARD Anne Arundel Co Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Blackwhite

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	6	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Daisy Crook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records

15 Filed OCT 10 1924, 19 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Oct 9, 1927, that I last saw him alive on Oct 9, 1927, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ....yrs. ....mos. 1 2 ds.

CONTRIBUTORY (Secondary) Mediastinal tbc

(duration) ? yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

10/10, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy M.P. Cem	10/11 1927
20 UNDERTAKER	ADDRESS
Jas. W. Holmes	1625 E. Lead St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90945

CERTIFICATE OF DEATH.

31 D 90945

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Harford ave ST., 9 WARD)

2-FULL NAME Joseph Anzer

(a) RESIDENCE NO. 2224 Harford av ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise A Anzer.

6 DATE OF BIRTH (month, day, and year) Sept 2nd

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
46		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Anzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Anzer

(Address) 2224 Harford ave

15 Filed ..... Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Oct 9, 1924, that I last saw him alive on Oct 8, 1924, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. — mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Was known of about some time ago

(Signed) T. E. Alle M. D.

10/10 19 24 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Loudon Park — DATE OF BURIAL Oct 11 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

Filed 10 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90946

CERTIFICATE OF DEATH.

74-801 D 90946

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5415 Winner Ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Lena H Ramely

(a) Residence No. 5415 Winner Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas M Ramely

6-DATE OF BIRTH (month, day and year) Sept 8th

7-AGE. 65 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Joseph Ramely

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Minnie Nelker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Ora Skinner

(Address) 5415 Winner Ave

15- 192

OCT 10 1924 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 12 1924 to Oct. 8 1924

that I last saw h[illegible] alive on Oct 8 1924

and that death occurred, on the date stated above, at 4:30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Unknown mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. What test confirmed diagnosis? Physical Signs

(Signed) W K Ingram M. D

19 (Address) 1324 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 8th 1924
20-UNDERTAKER. Tom Cook	ADDRESS 722 E North Ave

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should fill in ONLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90947

CERTIFICATE OF DEATH.

D 90947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 287 E. Franklin Ave (ST.) (WARD) Rogelberg

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Greensfelder

(a) RESIDENCE NO. 287 E. Franklin ave. (ST.) Rogelburg. (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Greensfelder

6 DATE OF BIRTH (month, day, and year) Jan 28th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Mulfinger

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Henry Greensfelder
(Address) 287 E. Franklin Ave. Rogelburg

15 Filed OCT 10 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to Oct 9, 1924, that I last saw her alive on Oct 8, 1924, and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Geary F. Eng M. D.

Oct 12 1924 (Address) 27 N. Fairfield Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Oct 12 1924
20 UNDERTAKER Fred'k Isaac & Sons	ADDRESS Fulton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.—400 Bks.

D 90948 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 90948

93

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 N. Port St. St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Barbara Stoehl

(a) Residence No. 617 N. Port St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Stoehl.

6-DATE OF BIRTH (month, day and year) Nov. 24-1873

7-AGE. 50 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home
(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER. Joseph Hoffmann

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER Kunigunda Mayr

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country). Germany

14- (Informant) Otto Stoehl
(Address) 617 N. Port St.

15- Filed Oct 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). October 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1-1924 to Oct. 9 1924, that I last saw h[illegible] alive on Oct 9 1924, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:
Sepsis following Varicose ulcer.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Cardiac dilatation.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis A. DeKrause M. D
, 19 (Address) 2500 S. Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL. Oct. 11 1924

20-UNDERTAKER. Lilly and Zeiler — ADDRESS 403 S. Wolfe St.

T 10 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90949

CERTIFICATE OF DEATH.

159 D 90949

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 Fawcett. ST., W WARD)

2-FULL NAME Hida M. Buchman.

(a) RESIDENCE NO. 432 Fawcett. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 27 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	27.	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm F Buchman

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Hida M Hackley

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm F Buchman. (Address) 432 Fawcett St.

15 Filed OCT 10 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1924, to Oct 10, 1924, that I last saw h[illegible] alive on Sept 30, 1924, and that death occurred, on the date stated above, at 715 A m.

The CAUSE OF DEATH* was as follows:

Spina bifida

..... (duration) ..... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe H Cross, M. D.

Oct. 1924 (Address) 1458 Marylander

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden.	10/11 1924
20 UNDERTAKER Walter Davis	ADDRESS 3307 Paine St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90950

CERTIFICATE OF DEATH.

D 90950

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2704 Tivoly Ave. WARD 9

2-FULL NAME Mary Florence Stringfield.

(a) RESIDENCE. No. Mason 36 Masonville WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Arnold

6 DATE OF BIRTH (month, day, and year): Nov. 6.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): a.a. Co Md.

PARENTS

10 NAME OF FATHER: Wm a Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): a. a. Co Md.

12 MAIDEN NAME OF MOTHER: Achsah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): a.a. Co Md.

14 Informant: Robert Arnold (Address) Mason 36 Masonville Md.

15 Filed Robert P. Harrison Registrar

T 10 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1924, to Oct 9, 1924, that I last saw h[illegible] alive on Oct 9, 1924, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chronic nyocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

(Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 13 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	910 Eutaw Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 90951

CERTIFICATE OF DEATH.

8 129 D 0095

1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 N. Wolfe Street St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Fitzpatrick,

(a) Residence No. 1519 N. Wolfe Street St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? life yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) 8/11/1858

7-AGE. 66 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore, (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Bernard J, Fitzpatrick

11-BIRTHPLACE OF FATHER (city or town) Ireland (State or Country),

12-MAIDEN NAME OF MOTHER, Catherine Greegan

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country),

14- (Informant) Bernard Fitzpatrick

(Address) 1519 N. Wolfe Street

15- Robert P. Harrison, Registrar.

T1 D 1924

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10 | 7 | 1924

17- I HEREBY CERTIFY, That I attended deceased from July 5 19 24 to Oct 7 19 24

that I last saw h.. alive on Oct 7 19 24

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... yrs. 3 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no What test confirmed diagnosis? Physical Examination

(Signed) H. J. Hanna M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cemetery	10/11, 19 24
20-UNDERTAKER. George J. Ruth	ADDRESS 1735 HARFORD AVE/

Per A.H.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 E North ave St., 9 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Eleonora Strodtman

(a) Residence No.... 1010 E North ave St.,.... Ward....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) ~~WIFE~~ of Frederick Strodtman

6-DATE OF BIRTH (month, day and year) August 16th 1846

7-AGE, 78 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. W. D. Read

(Address) 1010 E North ave

15- Filed ....., 192.... Registrar.

Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 15, 1924 to Oct 10, 1924 that I last saw h.. alive on Oct 10, 1924 and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Asteriosclerosis, Cardio Renal Disease

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy Failure

Complication (Duration) yrs. 30 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Microscopic

(Signed) J. Wallace Thomas, M. D.

Oct 10 1924 (Address) 1228 E Cold Spring

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 13th 1924

20-UNDERTAKER, George A. Schilling & Sons ADDRESS 1126 E Monument

25

1 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90953

CERTIFICATE OF DEATH.

5 129

D 90953

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 235 Forrest ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Ellis

(a) RESIDENCE. No. 235 Forest ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thos H. Ellis

6 DATE OF BIRTH (month, day, and year) Jan 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Farm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Cannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Smith
(Address) 135 Forest

15 Filed Robert P. Harrison, Registrar

OCT 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Oct 8, 1924, that I last saw h. w alive on Oct 7, 1924, and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Dis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? W Date of

Was there an autopsy? W

What test confirmed diagnosis?

(Signed) W Chas de Burnes, M. D.

10-9-24 19 (Address) 2017 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 11 1924

20 UNDERTAKER Liston P. Russelbaugh ADDRESS 2620 St Paul,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90954

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 935 Rutland av St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Kelso

(a) Residence No. 935 Rutland av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced WIFE of (or) HUSBAND of Maggie Kelso

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 1 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS:
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mr. H. Kelso (Address) 935 Rutland av

15- Filed ..... 192 Robert P. Harrison Registrar.

OCT 11 1924

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1924 to Oct 9 1924, that I last saw h. ~~co~~alive on Oct 8 1924, and that death occurred, on the date stated above, at 5 45 am.

The CAUSE OF DEATH* was as follows:

Apoplexy

6 Days (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Dilitation of heart

..... (Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward Fisher M. D.

10-9, 1924 (Address) 1612 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Oct. 13, 1924
20-UNDERTAKER,	ADDRESS
Mrs. Kate R. Willis	322 N. Schroeder St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90955

CERTIFICATE OF DEATH.

129 D 90955

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1523-W-Fairmount St., (Ward) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Johnson

(a) RESIDENCE No. 1523-W-Fairmount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Nellie Scribner (Niece)

(Address) 513 N. Stricker

15 Robert P. Harrison, Registrar

OCT 11 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1924, to Oct 8 1924, that I last saw h[illegible] alive on Oct 8, 1924, and that death occurred, on the date stated above, at 6, 15 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insuf.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Physical

(Signed) Walter J. Dorsey Jr., M. D.

, 19 (Address) 618 W. Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetry — DATE OF BURIAL: Oct 11, 1924

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 90956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4/ D 90956

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 W Lombard ST. 18 WARD)

2-FULL NAME Mary Clark

(a) RESIDENCE. No. 1144 W Lombard ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel C Clark

6 DATE OF BIRTH (month, day, and year) Dec 18th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rena Clark

(Address) 1144 W Lombard St

15 Filed OCT 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10-1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1924 to Oct 10th 1924, that I last saw h alive on Oct 9th 1924, and that death occurred, on the date stated above, at 3, a m.

The CAUSE OF DEATH* was as follows: Pneumonia Left Lung.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) S. K. Hutton, M. D.

. 19 (Address) 829 N. Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Alex Cem	Oct 13 19 24

20 UNDERTAKER John J Fields ADDRESS 1208 W Lombard St

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 90957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90957

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 713 Harvey St., 24 Ward)

Registered No.....

2-FULL NAME Grayer Peterson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 713 Harvey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Andrew C Peterson

6-DATE OF BIRTH (month, day and year) September 22

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Geo W Haffenny

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Helen Nunks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md.

14- (Informant) Andrew C Peterson

(Address) 713 Harvey St

15- Filed OCT 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-8-24

17- I HEREBY CERTIFY, That I attended deceased from 9. 1. 24, 19 to 10. 8. 19 24

that I last saw him alive on 10. 7. 19 24

and that death occurred, on the date stated above, at 3.15A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & metastasis to Pelves & Intestines

(Duration) dont know yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical examination

10.8 (Signed) J Edward Holmes, M. D.

24 19 (Address) 107 E. West St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	10-11, 1924
20-UNDERTAKER.	ADDRESS
E & R Hark	115 E West St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90958

HEALTH DEPARTMENT—CITY OF BALTIMORE

H D 90958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 230 S. Bolington ave St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hadfield

(a) Residence No. 230 S. Bolington St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.): M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jessie Hadfield

6-DATE OF BIRTH (month, day and year): May 1876

7-AGE: 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Insane

(b) General nature of industry, business, or establishment in which employed (or employer): Hosp.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): England

PARENTS.

10-NAME OF FATHER: John Hadfield

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Deatharon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Eng

14-

(Informant): Jessie Hadfield

(Address): 230 S. Bolington

15-

1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk

T 1

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 19 24 to Oct 8 1924

that I last saw h[illegible] alive on Oct 7 19 24

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? yes Date of June 11

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Greenmount Cemetery	Oct 11th 19 24
20-UNDERTAKER J. A. Moran	ADDRESS 3000 E Balto.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful to have CAUSE OF DEATH correctly classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2035 E. Clifton ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Miller

(a) Residence No. 2035 E. Clifton ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND ~~of (or) WIFE~~ of Eliz. Miller

6-DATE OF BIRTH (month, day and year) Sept 29-1892

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). B & O R.R.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. John Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). City

12-MAIDEN NAME OF MOTHER. Anderson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). City

11- (Informant) Bessie Miller

(Address) 2035 Clifton ave

13- Filed..... 19?? Robert P. Harrison, Registrar.

CT 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 8, 1924.

17- I HEREBY CERTIFY, That I attended deceased from September 8 19 24 to October 8 19 24 that I last saw him alive on October 8 19 24 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH was as follows:

Typhoid Fever.

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 3. ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination. Was Laboratory Test Made? Albert C. Bamberg, M.D.

10/9/ 1924 (Address) 2027 E. North Ave

(State the Disease Causing Death, or in deaths from Violent Causes state (1) the Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. | DATE OF BURIAL, Oct 11 19 24

20-UNDERTAKER. J.G. Moran | ADDRESS 7000 E Baltimore.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 90960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90960

CERTIFICATE OF DEATH.

106-03

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizah Clark

(a) Residence No. Bay View Asylum 1403 Orleans St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occured unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Municipal Hospital Records

(Address)

15- Dec....., 192.....

Registrar.

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-9-24

17- I HEREBY CERTIFY, That I attended deceased from 4-2, 1924, to 10-9, 1924

that I last saw him alive on 10-9, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sen

(Signed) Claude A. Evans, M. D.

10-9, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel

DATE OF BURIAL, Oct 13, 1924

20-UNDERTAKER. Sam'l W Case Sons

ADDRESS 1400 Madison

OCT 1 1924

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90961

D 90361

172

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

2-FULL NAME Anna Costello

(a) RESIDENCE NO 1111 E. Balto. St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Costello

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Chas. Erickson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Mary Ellen Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant Martin Costello
(Address) 1111 E. Balto St

15 Filed ....., 192 Robert P. Harrison, Registrar

T 1 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken back &internal injuries
(Jumped from roof 3rtory building
probably suicide)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Insanity

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Collins, M. D.
(Coroner.)

Oct 10/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn

DATE OF BURIAL Oct 11 1924.

20 UNDERTAKER Kendall & Lippel

ADDRESS 37 W. Lanvale

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loudlen Summers

(a) RESIDENCE NO. 1143 Hamberl St., Lo WARD Point

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1924

7 AGE — Years: — Months: 4 Days: 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Colored child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Harry Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary Defl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1924, to Oct 10, 1924, that I last saw h... alive on Oct 10, 1924, and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary) - 7 hours

(duration) ..... yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.

Oct, 19 24 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 10-11 1924

20 UNDERTAKER: Chas. L. Sherma ADDRESS 1501 Fulton Ave

T1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of O... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90963

CERTIFICATE OF DEATH

D 90963

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED No.....

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ralph Keyes

(a) RESIDENCE No 1022 North Central ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Keyes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Bratten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary E Keyes
(Address) 1022 N. Central Ave

15 Filed OCT 11 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-intestinal indigestion
Unexplained convulsions
(Autopsy at hospital)
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Mullen, M. D.
(Coroner.)

10/11/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., 3 Hours ds. In the State ..... yrs., 3 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1022 N. Central Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 11 192

20 UNDERTAKER J. E. Cook — ADDRESS 502 E. North Ave

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others will please state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90964

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill ST. Westport WARD)

2-FULL NAME Lena White

(a) RESIDENCE NO. Cherry Hill ST., Westport WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If ~~married, widowed,~~ or divorced
~~HUSBAND~~ of
(or) WIFE of. Charles White

6 DATE OF BIRTH (month, day, and year) Aug 3 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Hoke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles White
(Address) Westport

15 Filed Oct 11 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1924, to Oct 10, 1924, that I last saw her alive on Oct 2, 1924, and that death occurred, on the date stated above, at 10.6a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs and Intestines

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Raymond B Glaum, M. D.

Oct 10, 1924 (Address) Lutherville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 13 1924
20 UNDERTAKER	ADDRESS
H. H. Cook	502 E Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90965

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 14 WARD)

2-FULL NAME William Kirk

(a) RESIDENCE NO. St Vincents Inf Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1924

7 AGE: Years —"— Months 4 Days 12 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —"—

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER Wm. August

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Koch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Nov 1 1924 , 19 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 9, 1924, that I last saw him alive on Oct 9, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery)

(duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) ... yrs. ... mos. 16 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, Hoffud Road

DATE OF BURIAL Oct 11 1924

20 UNDERTAKER J. M. Cook

ADDRESS 502 E Monument

NAME, RESIDENCE, AGE should be stated EXACTLY. PHYSICIANS should write legibly. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write legibly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 99966

CERTIFICATE OF DEATH.

D 99966

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc. Farland

(a) RESIDENCE NO. 638 N. Gilmor st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John Mc Farland (S)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Conlon (D)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Brother Wm McFarland (Address) Homewood apts city

15 Filed OCT 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 10, 1924, that I last saw him alive on Oct 10, 1924, and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No. Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Cystoscopy

(Signed) B.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Oct 13 1924

20 UNDERTAKER — ADDRESS N. Y Pa

N.B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Each item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90967

CERTIFICATE OF DEATH.

D 90967

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Eutaw Place ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie J. Dickson

(a) RESIDENCE No. 1618 Eutaw Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Dickson

6 DATE OF BIRTH (month, day, and year) 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	79	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mr. R. Proeddale

(Address) 1618 Eutaw Place

15 Filed OCT 1 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/24. 19

17

I HEREBY CERTIFY, That I attended deceased from July, 1923, to Oct. 9, 1924.

that I last saw h[illegible] alive on Oct 9, 1924

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis.

Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Whitehorne, M. D.

19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/11/ 19 24

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 98968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 98968

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE, (NO. ..... ST., 1 WARD)

2-FULL NAME Charles H. Potter

(a) RESIDENCE NO. 869 St Nicholas ST., N. 4 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estta Potter

6 DATE OF BIRTH (month, day, and year) April 16 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Eugene Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed OCT 11 1924, 19 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924, to Oct 10, 1924, that I last saw him alive on Oct 10, 1924, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) 1 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? New York ?

Did an operation precede death? yes (Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pathological sections Blood Chemistry

(Signed) Surgical Staff Johns Hopkins Hosp. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and (2) Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City-N Y	Oct 11 1924

20 UNDERTAKER John O Mitchell ADDRESS 1020 W Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90969

D 90969

CERTIFICATE OF DEATH.

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2718 St Paul ST., 17 WARD)

2-FULL NAME Emily C. Buck

(a) RESIDENCE NO. 2718 St Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced (or) WIFE of H. Best Buck

6 DATE OF BIRTH (month, day, and year) Oct 17 1842

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
81	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Henry Hoover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co., Md

12 MAIDEN NAME OF MOTHER Emily Weller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md

14 Informant Beulah M. Dembracco (Address) 2718 St. Paul St.

15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1923 to Oct 10, 1924.

that I last saw h-er alive on 10/9, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. Laboratory

(Signed) H. W. Hoff M. D.

10/10 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 13 1924

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette

T 1

IMPORTANT—THIS CERTIFICATE REQUIRES UNUSUALLY ACCURATE ANSWERS. Every question on both sides should be carefully answered. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90970

D 90970

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5307 York Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Wing ~~Han~~ Gin

(a) RESIDENCE NO. 5307 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	chinese	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Gin

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Lee Wah

(Address) Wolfe and Eager St

15 OCT 1 1924 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1924, to Oct 9th, 1924,

that I last saw him alive on Oct 1st, 1924,

and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan M. D.

Oct 10, 1924 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Oct 13 1924

20 UNDERTAKER John B. Mitchell ADDRESS 201 W Fayette

IMPORTANT—THIS CERTIFICATE MUST BE CAREFULLY AND COMPLETELY FILLED IN WITH UNFADING INK. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90971

D 90971

CERTIFICATE OF DEATH.

REGISTERED NO. 100081

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6536 Fait Ave. Hudson Height ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Idalia E. Howe.

(a) RESIDENCE No. 6536 Fait Ave. Hudson Height ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Batny

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year) Aug 9 - 1924

7 AGE: Years — Months 2 — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Howe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bathe Maine

12 MAIDEN NAME OF MOTHER Idalia Rodrigo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant (Address) Idalia Howe. 6536 Fait Ave

Filed OCT 11 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1924, to Oct 9, 1924

that I last saw her alive on Oct 9, 1924

and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) X yrs. X mos. 4 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas L. Fraser M.D.

(Address) 248 So 32d St

19 Oct. 10 24

*Glance the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Oct 11 1924

20 UNDERTAKER: Gus C. Miller & Son — ADDRESS 2334 Jefferson St

* THIS DEPARTMENT RECORD. Every item should be stated EXACTLY, with UNABRIDGING PENCIL. AGE should be carefully supplied. PHYSICIAN'S mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 90972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90972

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Montford Ave St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Pack.

(a) RESIDENCE NO. 215 N. Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colord

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married

6 DATE OF BIRTH (month, day, and year) march 4 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
55				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: george dickson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: mary johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: catherine Bodley

(Address) 407 S. spring st

15 OCT 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-1924

17

I HEREBY CERTIFY, That I attended deceased from 10-3-1924, to 10-8-1924, that I last saw h alive on 10-5-1924, and that death occurred, on the date stated above, at 2,30 P. m.

The CAUSE OF DEATH* was as follows:

mitral insufficiency

heart Dis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis. Endocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 611 N. Carolin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: loudon cemetery — DATE OF BURIAL: Oct 11 1924

20 UNDERTAKER: Edward Bryan — ADDRESS 1671 orleans st

N.B.—WHEN PRINTED, WITH ENGRAVING—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

GE should be stated EXACTLY. PHYSICIANS should t it may be properly classified. Exact statement of OC on back of certificates.

Cor.—4-12-23—M&T—100 Bks.

D 90973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Brickyard 8th & Monument ST., 7 WARD)

REGISTERED NO. 185 D 90973

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. James Randolph

(a) RESIDENCE No. 1502 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Randolph

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Brick Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER John Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Edith Randolph (Address) 1502 Ashland Ave

15 Filed OCT 11 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insuufficiency

(Fell from Hhorse.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute indigestion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Rouse, M. D.
(Coroner.)

10/11/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Oct 13 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

AGE should be stated EXACTLY. PHYSICIANS should state it accurately supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 90974

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90974

CERTIFICATE OF DEATH.

161-08

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 15 WARD)

2-FULL NAME Baby Montague

(a) RESIDENCE NO. 1714 N. Carey St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day .3 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Blanche Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed OCT 7 1924 Robert P. Heston, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/5, 1924, to 10/5, 1924, that I last saw him alive on 10/5, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E L Stone, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL OCT 11 1924 19

20 UNDERTAKER ADDRESS

Bureau of Vital Statistics

Commissioner of Health,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 90975

HEALTH DEPARTMENT—CITY OF BALTIMORE

182D 90975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found - Water at foot

CITY OF BALTIMORE: (No. Lancaster ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hlobik

(a) RESIDENCE No. 131 S Spring ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? 5 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Copper miner
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Balto Copper Works

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Hlobik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hlobik

(Address) 131 S Spring St

15 Date OCT 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental
Drowning

(duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenlon, M. D. (Coroner.)

Oct 11, 1924 (Address) 700 Albert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? -

Former or usual residence 131 S. Spring St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Oct. 11 1924
20 UNDERTAKER	ADDRESS
Stephan J. Fralkowski	1000 S. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 90976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90976

CERTIFICATE OF DEATH.

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4808 Ferndale Ave ST.; 28 WARD)

2-FULL NAME Ellen Benton Maxwell

(a) RESIDENCE No. 4808 Ferndale Ave ST.; WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Maxwell

6 DATE OF BIRTH (month, day, and year): Jan. 13, 1862

7 AGE — Years: 62 — Months: 8 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER: Benj. S. Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vt

12 MAIDEN NAME OF MOTHER: Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Mrs. Wm R. Haines

(Address) 4808 Ferndale Ave

15 Filed ....., 19 Robert F. Carrison

Registrar

CT 11 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to Oct 8, 1924,

that I last saw h[illegible] alive on Oct 8, 1924,

and that death occurred, on the date stated above, at 4.45 am.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 20 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Laboratory

(Signed) F.S. Robertson M. D.

, 19 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL: Oct 13 1924

20 UNDERTAKER: Wm Fickus Sons — ADDRESS: North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90977

43 D 90977

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2853 Woodbrook Ave. St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette C. Caprise

(a) RESIDENCE NO. 2853 Woodbrook Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Caprise

6 DATE OF BIRTH (month, day, and year) June 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	64	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Thomas Blaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabelle Weatherstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Miss Mollie Rector (Address) 2853 Woodbrook Ave.

15 Filed OCT 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1924, to Oct 11, 1924.

that I last saw h[illegible] alive on Oct 10, 1924

and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Edw Shorb, M. D.

Oct 11, 1924 (Address) 1353 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae — DATE OF BURIAL Oct 14 1924

20 UNDERTAKER Wm Pickrell Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 90978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 3/ D 90978

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Sydney E. Mudd

(a) RESIDENCE NO. 2e Plata Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Congressmen

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Gallant Green
(State or country) Charles Co. Md

PARENTS

10 NAME OF FATHER Sydney E Mudd

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Gallant Green Md

12 MAIDEN NAME OF MOTHER Mary J. Griffin

13 BIRTHPLACE OF MOTHER (city or town) Union
(State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1924, to Oct 11, 1924,
that I last saw h/m alive on Oct 11, 1924,
and that death occurred, on the date stated above, at 9.15 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
" Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Martin A Barber, M. D.

, 19 (Address) 115 E Saint St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stewart & Mawsons	Oct 12 1924
20 UNDERTAKER	ADDRESS
Washington D.C.	1018 N. Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90979

100-00 D 90979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1722 N. Charles St., 23 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Herzberger

(a) Residence No. 1722 N. Charles St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Herzberger

6-DATE OF BIRTH (month, day and year) July 18th 1850

7-AGE. 74 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Work

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germy

PARENTS.

10-NAME OF FATHER. Jacob Gernert

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germy

12-MAIDEN NAME OF MOTHER. Catherine Gernert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germy

11-

(Informant) Joseph F. Herzberger

(Address) 1722 N. Charles St.

Filed OCT 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 19 24 to Oct 10 19 24

that I last saw h.. alive on Oct 9th 1924

and that death occurred, on the date stated above, at 6.20 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hawkins M. D.

10/11, 19 24 (Address) 6 Pendleton Ct.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill Cem	Oct 13th 1924
20-UNDERTAKER.	ADDRESS
E. Schumacher & Son	Hanover & W

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

D 90980

CERTIFICATE OF DEATH.

D 90980

1-PLACE OF DEATH

City of BALTIMORE: (No. 1020 Valley Street St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel J. Hughes

(a) Residence No. 1020 Valley Street St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Robert Hughes

6-DATE OF BIRTH (month, day and year) 11/4/1895

7-AGE. 28 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael H.Caton

11-BIRTHPLACE OF FATHER (city or town) Baltimore, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary O'Brein

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Robert Hughes

(Address) 1020 Valley Street.

OCT 12 1924

Filed ROBERT R. KRAUTER,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) OCT 10 1924

17- I HEREBY CERTIFY, That I attended deceased from OCT 1 1924 19.. to OCT 10 1924

that I last saw h.....alive on OCT 10 1924

and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH was as follows*

Hypostatic Pneumonia
and Dilated heart

(Duration) 1 yrs. X mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) C. H. Duker M. D.

OCT 11 1924 (Address) 928 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudenslager Cemetery	10 13, 1924
20-UNDERTAKER.	**ADDRESS**
George J. Kuth	1730 Harford Ave

N. B.—WRITE LEGIBLY. SPELL EVERY WORD EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 90981 — 57 — D 90981

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Eden St., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Zinz

(a) RESIDENCE NO. 225 S Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Zinz

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1432 E Fayette

15 Filed OCT 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct. 10, 1924

that I last saw h alive on Oct 10, 1924

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis,

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W J Danglin, M. D.

10/11, 1924 (Address) 210 S Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rebert Herring Bur

DATE OF BURIAL 10/11 1924

20 UNDERTAKER Jack Levis

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90982

CERTIFICATE OF DEATH.

13 ✓ D 90982

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 E. Crattan St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mendal Rottin (Rottin)

(a) Residence No. 1008 E. Pratt St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Rottin

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Israel Rottin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER Thens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis (Address) 1429 Baltic St

15- Filed OCT 1 1924 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/4/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1924 to Oct 4 1924, that I last saw him alive on Oct 4 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Dilated Heart

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Underwood M. D.

10/5 19 (Address) 2328 Madison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Herbert Rosedale — DATE OF BURIAL, 10/11 19 24

20-UNDERTAKER. Jack Lewis — ADDRESS

N. B.—WRITE LEGIBLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90983

CERTIFICATE OF DEATH.

111-001

D 90983

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 14 WARD)

2-FULL NAME Mr. Abraham Loobar

(a) RESIDENCE No. 2811 Linden Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rena Loobar

6 DATE OF BIRTH (month, day, and year) Russia

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bag Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abram Loobar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Kirshner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lours 1429 Walker

15 Filed OCT 21 1924 ROBERT F. KRAUTER Registrar
(Special Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Oct 10, 1924.

that I last saw him alive on Oct 10, 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gastric ulcer.

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of 9/24/24 10/10

Was there an autopsy? Gastro enterostomy Yes. Return of pathologist

What test confirmed diagnosis? Operation

(Signed) Ernest S. Edlavitch, M. D.

10/10, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 10/12 1924

20 UNDERTAKER Jack Lours 1429 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90984

CERTIFICATE OF DEATH.

113 D 90984

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Eastern Avenue ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna. Koch

(a) RESIDENCE NO. 1739 Eastern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Anthony. Koch

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Wanda. Karlowski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr Anthony . Koch
(Address) 1739 Eastern Ave.

15 Filed [illegible] 19 [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 24 to Oct 8, 19 24.

that I last saw h[illegible] alive on Oct 8, 19 24

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Justus Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Wallerstein, M. D.

, 19 (Address) 14 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct. 13 1924
20 UNDERTAKER	ADDRESS
John B. Weber	1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Duerbeck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90985

D 90985

CERTIFICATE OF DEATH.

90

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3117 monticello ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME matilda a Durbeck

(Residence in Baltimore: No. 3117 monticello ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, December 25 (Month) (Day), 1872 (Year)

7-AGE, 52 yrs. 9 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Stange

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Durbeck

Husband

(Address) 3117 monticello ave

15- OCT 12 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1924, to October 11 1924, that I saw her alive on October 10 1924, and that death occurred, on the date stated above, at one m.

The CAUSE OF DEATH* was as follows:

Kidney disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of the Heart

(Duration) yrs. mos. ds.

(Signed) H. Spanier Whitbeck M. D.

Oct 11, 1924 (Address) 601 S. Goodrich Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer. DATE OF BURIAL, Oct 14, 1924

20-UNDERTAKER E. A. Medefield ADDRESS 501 E 22 St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 90986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D 90986

REGISTERED NO.

1-PLACE OF DEATH Found at foot of Lawton St., (No. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.

2-FULL NAME Guy Kuhner

(a) RESIDENCE No. Steamship Pomodo St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman 886
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Steamship Pomodo

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Kuhner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr Fenton
(Address) 600 E Chase st

15 Filed OCT 12 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) Instantly yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) James W Fenton, M. D.
(Coroner)

Oct 10. 1924 (Address) 600 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery

DATE OF BURIAL 10/12 1924

20 UNDERTAKER Joe Thomson & Bro

ADDRESS 1127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90987

CERTIFICATE OF DEATH.

118-001 D 90987

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

2-FULL NAME Richard A. Nelson

(a) RESIDENCE No. 939 Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maggie Nelson

6 DATE OF BIRTH (month, day, and year) Madch 3/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Nelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) B
(State or country)

14 Informant Maggie Nelson
(Address) 939 Park Ave

15 Filed OCT 12 1924 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Odema of lungs

(Auyopsy at Hopkins Hospital)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Strangulated Hernia (duration) ....yrs. ....mos. ....ds.

(Signed) D A Watkins, M. D.
(Coroner.)

10/11/24. 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Oct 12 1924

20 UNDERTAKER Samuel I Hrusky — ADDRESS 1728 Mc Elderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D 90988

CERTIFICATE OF DEATH.

D 90988

REGISTERED NO.....

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. Fairmount & Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William Doyle

(a) RESIDENCE NO. 113 N Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Doyle

6 DATE OF BIRTH (month, day, and year) Sept 20 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Cashbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Elizabeth Doyle

(Address) 113 N. Bradford St

15 OCT 12 1924 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Oct 9, 1924.

that I last saw him alive on Oct 9, 1924

and that death occurred, on the date stated above, at 10:15a m.

The CAUSE OF DEATH* was as follows:

Poly cystic Kidneys

Primary:—Encephalitis following Influenza (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Oct 1918

Did an operation precede death? No Date of Jan 25 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) K L Krieg, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Oct 13 1924
20 UNDERTAKER	ADDRESS
N. Gander & Sons	1710 Fleet St.

K. L. Krieg.

Expat Australia

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90989

CERTIFICATE OF DEATH.

73 D 90989

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1713 N. Bond St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fink

(a) Residence No. 1713 N. Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Fink

6-DATE OF BIRTH (month, day and year) Dec 5, 1862

7-AGE. 61 yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Business

(c) Name of employer Gunther & Fink

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Fink

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Abellein

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Hannah Fink

(Address) 1713 N. Bond St.

15- Filed OCT 12 1924, ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1924 to Oct 11 1924

that I last saw him alive on Oct 7 1924

and that death occurred, on the date stated above, at 1 10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Anderson M. D.

, 19 (Address) 1714 N Carlton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Oct 13, 1924
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Blks.

D 90990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/17

D 90990

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sister Cecilia Sullivan

(a) Residence No. St. Agnes Hospital, Baltimore, Md. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 22 yes 1857

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Providence, R.I.
(State or Country).

PARENTS:

10-NAME OF FATHER. Eugene Sullivan

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary O'Leary

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Ireland

11- (Informant) St Agnes Hospt

(Address) Wilkens ave

15- Filed OCT 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 192.. to October 10th 1924

that I last saw her alive on October 10th 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J F Oliveira M. D.

. 19 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Southwood

DATE OF BURIAL. Oct 13, 1924

20-UNDERTAKER. Martin Tuskey Son

ADDRESS 1824 W Pratt

N. B.—WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90991

CERTIFICATE OF DEATH.

D 90991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Grantley Rd ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas C Gosnell

(a) RESIDENCE NO. 3807 Grantley Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida B Gosnell

6 DATE OF BIRTH (month, day, and year) June 24 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
74	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER D. E. Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Helen Coulson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Willard B Jones (Address) 3807 Grantley Rd

15 Filed OCT 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 19 24, to Oct 10, 19 24,

that I last saw him alive on Oct. 10, 19 24;

and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Chas V Coolahan, M. D.

, 19 (Address) 84 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Oct 13 19 24

20 UNDERTAKER Harry H Armacost 4204 A — ADDRESS Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

B 90992 HEALTH DEPARTMENT—CITY OF BALTIMORE D 90992

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2834 ODonell St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Stanley Wagner

(a) Residence No. 2834 ODonell St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. - mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 10 1924

7-AGE, ... yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant)... Father Wagner

(Address)... 2834 ODonell St

15- OCT 12 1924 Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12-1924

17- I HEREBY CERTIFY, That I attended deceased from 10-12-, 1924, to 10-12-, 1924, that I last saw h.. alive on 10-12- 19 24 and that death occurred, on the date stated above, at 5-30 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronstein, M. D.

1012 (Address) 3037 ODonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Stanislaus Cem DATE OF BURIAL, Oct 13, 1924

20-UNDERTAKER Stephen J Kalkowski ADDRESS 1000 Hanover St.

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90993

CERTIFICATE OF DEATH.

D 90993

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 Lafayette Ave. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Howe

(a) Residence No. 1618 Lafayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced. HUSBAND of (or) ~~WIFE of~~ Katherine J. Howe

6-DATE OF BIRTH (month, day and year) Aug. 3-1861

7-AGE.	If LESS than 1 day,
63 yrs. 3 mos. 7 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Katherine J. Howe

(Address) 1618 E. Lafayette Ave.

15- OCT 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-16-24

17- I HEREBY CERTIFY, That I attended deceased from 9-30 1924 to 10-10 1924

that I last saw him alive on 10-9 1924

and that death occurred, on the date stated above, at 1:54 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M.D.

10-12-24 (Address) 58 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	10/13, 1924

20-UNDERTAKER.	ADDRESS
C.F. Evans & Son, Inc.	118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90994

CERTIFICATE OF DEATH.

90 D 90994

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 James ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Smolskis

(a) RESIDENCE. No. 1201 James ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) no. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER no

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER no

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr Joseph Smolskis

(Address) 201 Inner St

OCT 1 1924

File

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 10 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 10- 8- 1924, to 10 - 10 - 1924, that I last saw him alive on 10 - 9 - 1924, and that death occurred, on the date stated above, at 1.00 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease, followed by Left Hemiplegy (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) O. B. Brownsbas, M. D.

10- 2 1924 (Address) 3037 Edmondell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Oct 13 1924
20 UNDERTAKER	ADDRESS
John A. Grebiauskas Jr.	425 So. Paca St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90995

CERTIFICATE OF DEATH.

X 185 D 90995

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emory Frost

(a) RESIDENCE NO Deep Creek Cove ST., Essex WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna May Frost

6 DATE OF BIRTH (month, day, and year) 7/31/1891

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
33	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS

10 NAME OF FATHER John Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anna May Frost
(Address) Deep Creek Cove Essex

15 Filed OCT 2 1924 192 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 0 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crush. Chest and skull internal injuries. Accidental Fall from Bldg. Dr. Hopkins + Howard M. D.
7 hs. duration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... , M. D.
(Coroner.)
Oct 12, 192 4 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	10/13/24 192
20 UNDERTAKER George J. Pettis 1335	ADDRESS Hanford Cal

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 90996

CERTIFICATE OF DEATH.

D 90996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Elliott

(a) RESIDENCE NO. 914 Lemmon St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day,.. hrs. or min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Bartlett Hayward Co.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER George Elliott

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record
(Address)

OCT 1 2 1924

ROBERT R. KRAUTER,
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/24

17

I HEREBY CERTIFY, That I attended deceased from 10/10/24, 19..., to 10/12/24.

that I last saw him alive on 10/12/24

and that death occurred, on the date stated above, at 11 00 m.

The CAUSE OF DEATH* was as follows:

Liver (?)
Metast Transference

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Decomp

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Solomons Island Md

DATE OF BURIAL: Oct 15 1924

20 UNDERTAKER: J J Cowan

ADDRESS: 901 Hollins

Fire & Burglar Alarm Cabinet Co

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90997

CERTIFICATE OF DEATH.

D 90997

REGISTERED NO. 174377

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. [illegible] WARD)

2-FULL NAME George F. Hall

(a) RESIDENCE No. 1901 E. 5th St. ST., WARD Charlotte, N.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hall

6 DATE OF BIRTH (month, day, and year) 7.7.75

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Life Insurance Co. of Richmond Va.

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Samuel Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky ?

12 MAIDEN NAME OF MOTHER Annie Zerley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Hospital Records

(Address)

OCT 31 1924

ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 October 1924

17 I HEREBY CERTIFY, That I attended deceased from 4 June, 1924, to 12 October, 1924, that I last saw him alive on 12 October, 1924, and that death occurred, on the date stated above, at 5 32 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis of iliac arteries

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11 Oct 1924

Was there an autopsy? No

What test confirmed diagnosis? Confirmed at Autopsy

(Signed) Robert D. Gillespie, M. D.

(Address) Johns Hopkins Hospital, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte NC DATE OF BURIAL Oct 14 1924

20 UNDERTAKER Wm Pickner Sons ADDRESS Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 90998

CERTIFICATE OF DEATH.

89

D 90998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3024 Harford Ave Ward 9)

2-FULL NAME Edward Berge

(a) RESIDENCE No. 3024 Harford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Killian Stephens Berge

6 DATE OF BIRTH (month, day, and year) Jan 3 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
48	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sculptor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Berge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stuttgart Germany

12 MAIDEN NAME OF MOTHER Marylyn Brance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Killian S. Berge

(Address) 3024 Harford Ave

15 OCT 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1924, to Oct 12, 1924, that I last saw h alive on Oct 12 1924 and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 24 ds.

Arteriosclerosis

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Mayer M. D.

10/12/1924 (Address) 1404 Mayfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	Oct 14 1924
20 UNDERTAKER Wm J Beckner Sons	ADDRESS North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

90999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 90999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3024 E Monument ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August V. Russel

(a) RESIDENCE No. 3024 E Monument ST., 7 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Faulson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER M. Russel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert County Md

14 Informant Mr. Russel

(Address) 3024 E Monument St

Filed OCT 13 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30th, 1924, to Oct. 11th, 1924.

that I last saw him alive on Oct. 11th, 1924

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Rhinitis & Bronchitis

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Routine

(Signed) Elbert G. Reitzel, M. D.

Oct 11th 1924 (Address) 2734 Pa. Ave. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL Oct 13 1924

20 UNDERTAKER John C. Miller — ADDRESS 3019 E Monument St

Cor.—1-12-23—M&T—100 Bks.

D 91000 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5168. Light ST., 27 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Kate A. Forwood

(a) RESIDENCE No 5168 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER W. L. Forwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md ?

12 MAIDEN NAME OF MOTHER E. McC. Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant John W. Baroff
(Address) 716 N. Calvert

15 Filed OCT 13 1924 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Duration Dead Dead

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. Harry Forwood M. D.

Oct 10, 1924 (Address) (Coroner.) 1659 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 13 1924
20 UNDERTAKER Robt F Turner & Son	ADDRESS 1442 E. Broadway

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91001

CERTIFICATE OF DEATH.

90

D 91001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Burgundy ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Farner —

(a) RESIDENCE No 503 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced (write the word)
Male	Col	Marr'd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jas. Farner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clatworthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mamie Lewis
(Address) 503 Burgundy

15 Filed OCT 3 1924 ROBERT R. KNAPP Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease & Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) D K Ramsey, M. D.
(Coroner.)

10-10, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 13 1924
20 UNDERTAKER	ADDRESS
Samuel F Hensley	W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91002

D 91002

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1071 W. Lexington ST. WARD 6)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton D. Sampson.

(a) RESIDENCE. No. 1071 W. Lexington ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 19-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter in drug store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chas Browning.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Sampson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo. Sampson

(Address) 1071 W Lexington

15 Filed OCT 1 31924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7th, 1924, to Oct 10, 1924, that I last saw h[illegible] alive on Oct 9, 1924, and that death occurred, on the date stated above, at 3.35A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) F. C. Cusick, M. D.

Oct 10-24 (Address) North Ave & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 13, 1924
20 UNDERTAKER	ADDRESS
Jos. I. H. Rochester	1413 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91003
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D 91003
REGISTERED NO.

CITY OF BALTIMORE: (No. 612 N. 34th ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Isaac.

(a) RESIDENCE NO. 612 N. 34th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. 2. mos. 7. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A. Isaac.

6 DATE OF BIRTH (month, day, and year) Aug. 4 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2.	7.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER James Lilly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Ann Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Thomas A. Isaac.
(Address) 612 N. 34th St.

15 OCT 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17 I HEREBY CERTIFY, That I attended deceased from August 30th 1924 to October 11th 1924, that I last saw her alive on October 11th 1924, and that death occurred, on the date stated above, at 855 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos - ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph B. Saunders, M. D.

(Address) 719 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery. DATE OF BURIAL 10/14 1924

20 UNDERTAKER Walter Davis ADDRESS 3307 Paine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91004

CERTIFICATE OF DEATH.

100-001 D 91004

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Orleans St ST., 6 WARD)

2-FULL NAME Oscar Stancil

(a) RESIDENCE NO. 1724 Orleans St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Jany 12/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Oscar Stancil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va.

12 MAIDEN NAME OF MOTHER Blanche Cornicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va.

14 Informant Oscar Stancil
(Address) 1724 Orleans St

15 Filed OCT 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/24[92]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia (Primary-Prob.)

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

10/12/24. 192 (Address) 508 3. :9rth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cemetery	Oct 13 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U.S.A.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91005

CERTIFICATE OF DEATH.

113

D 91005

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2835 Bernard ST., 17 WARD)

2-FULL NAME Lillian Irene Brown

(a) RESIDENCE NO. 2835 Bernard ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 4-1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
—	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Sally E. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie M. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sally E. Brown

(Address) 2835 Bernard St.

OCT 13 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1924, to Oct 11, 1924, that I last saw h alive on Oct 9 1924, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac collapse

Hodgkin's disease (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) R B Tennent M. D.

Oct. 11 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakers (Balto. Co. Md.)	Oct. 13 1924
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91906 92 D

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabell Bennett

(a) RESIDENCE NO. 515 N. Bruce ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wilbert Bennett

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Gaden

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 10, 1924, that I last saw h[illegible] alive on Oct 10, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, acute

(duration) yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edgar H. Kemper, M. D.

10/11, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Sem

DATE OF BURIAL 10-12-24

20 UNDERTAKER Daniel Eagan

ADDRESS 916 Penna Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

474-001

D 91007

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie Montague

(a) Residence No. 427 N. Pine St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Md (State or Country),

PARENTS.

10-NAME OF FATHER, Tom Butler

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Catherine Woodland

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Municipal Hospital Records

(Address).....

15-

Filed OCT 13 1924 192 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-10-24

17- I HEREBY CERTIFY, That I attended deceased from 10-7, 1924 to 10-10 1924

that I last saw h.. alive on 10-10, 1924

and that death occurred, on the date stated above, at 5-0 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude E. Simms M. D

10-11 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL. 10-12-24

UNDERTAKER Daniel Cashou

ADDRESS 916 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-3-21—E.B.R.S.—400 Bks.

D 91008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91008

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1057 Raton St., 18 31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerad E Calhoun

(a) Residence No. 1057 Raton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col'd

5-Single, Married, Widowed, or Divorced, (Write the word.) Sing

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, Jas H. Calhoun

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country),

12-MAIDEN NAME OF MOTHER, Alberta Burns

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country),

14- (Informant) Jas H Calhoun

(Address) 1057 Raton

OCT 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 10 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 19 24, to Oct 10 19 24,

that I last saw h alive on Oct 7, 19 24,

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary

Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Tuberculosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray

(Signed) J Norwood, M. D.

Oct 13 19 24 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Zion Cemetery — DATE OF BURIAL, Oct 17th 1924

20-UNDERTAKER, Eugene Waters — ADDRESS 2466 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91009

CERTIFICATE OF DEATH.

D 91009

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Madison Ave ST., 14 WARD)

2-FULL NAME Elizabeth Wise

(a) RESIDENCE NO. 1915 Madison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richford Wise

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 29 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Samuel T. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Anderson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anderson, S. C.

14 Informant Richford Wise (Address) 1725 Broadway St.

15 Filed OCT 13 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1924 to Oct 10, 1924.

that I last saw h[illegible] alive on Oct 10 1924

and that death occurred, on the date stated above, at 11[illegible]45 a m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) 5 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. S. M. Hatcher, M. D.

10/13, 1924 (Address) 1225 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Oct 13 1924.

20 UNDERTAKER Samuel T Hemley. ADDRESS 578 W Bal

D 91010

Cor. 1-10-24—5T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91010

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 640 (St.) Maryland Ave (WARD) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah A. Ward

(a) RESIDENCE NO. 640 (St.) Md. Ave. (WARD) Brooklyn Balto-

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert F. Ward

6 DATE OF BIRTH (month, day, and year) June 22 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert F. Ward
(Address) 640 Md. ave. Brooklyn

15 Filed OCT 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Hr once yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. J. C. Horsley, M. D.
(Owner.)

Oct 10 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 13 1924
20 UNDERTAKER John F. Benning	ADDRESS 715 Lydia St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91011 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 31 D 91011

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3219 Belmont ave St. 18 (Ward) (Hospital Path)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert N Adams

(a) Residence No. 3219 Belmont ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male (white)

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Florida H Adams

6-DATE OF BIRTH (month, day and year) Dec 22 1886

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 090

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Adams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Clark Hasluft

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Chas Adams

(Address) 3211 Belmont ave

15- Filed OCT 13 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1909 to Oct 12 1924

that I last saw him alive on Oct 3 1924

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Tuberculosis

(Duration) 1 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Bc in Sputum

(Signed) Martin F. Doan M. D.

0.13. 192[illegible] (Address) 414 Prof. Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, Oct 14 1924

20-UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91012 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91012

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Towson ST., 24 WARD)

2-FULL NAME Madildy A Milby

(a) RESIDENCE No. 1428 Towson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Sept. 27, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert S. Milby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Polaschek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Mrs Barbara Polaschek

(Address) 1428 Towson St.

15 Filed OCT 1 3 1924 ROBERT H. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 11, 1924, that I last saw him alive on Oct 11, 1924 and that death occurred, on the date stated above, at 2-P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 Mo. Ultra Uterine)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. C. Campbell M. D.

Oct 12, 1924 (Address) 1644 Nanson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill. Cem.

DATE OF BURIAL: 10-13 1924

20 UNDERTAKER: Chas. S. Stevens

ADDRESS: 1501 Ft Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 57

D 91013

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Curry

(a) Residence No. 620 W. Redwood St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Amos Ennis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Mary Spang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Municipal Hospital Records

(Address)

15- Filed OCT 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-12-24

17- I HEREBY CERTIFY, That I attended deceased from 10-4, 1924, to 10-12, 1924

that I last saw h.. alive on 10-11, 1924

and that death occurred, on the date stated above, at 5-00 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Foot (Left)

(Duration) yrs. 1½ mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Hanes M. D.

10-12-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters — DATE OF BURIAL. Oct 14, 1924

20-UNDERTAKER John J. Fields — ADDRESS 1200 N. Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

91014

HEALTH DEPARTMENT—CITY OF BALTIMORE

91014

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.) 20 WARD)

2-FULL NAME Annie P. Schultz

(a) RESIDENCE No. 2630 Lehman ST.) ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. R. Schultz

6 DATE OF BIRTH (month, day, and year) Aug 28-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Francis O'Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas R. Schultz
(Address) 2630 Lehman St.

15 Filed OCT 1 3 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Liver & Internal Hemorrhage

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Auto accident

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Stanton M. D.
(Coroner.)

Oct 12 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct 14 1924

20 UNDERTAKER Easton Sons — ADDRESS Elliott & Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S 9105 T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/3 D 91015

REGISTERED NO. D 91015

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S. Bond ST. 3 WARD)

2-FULL NAME Elinora Wysocka

(a) RESIDENCE NO. 626 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Franek Wysocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Andrzejewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Franek Wysocki

(Address) 626 S Bond Street

Filed OCT 1 1924 ROBERT P. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9th, 1924, to Oct. 12, 1924, that I last saw her alive on Oct. 12, 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Aberdeen, Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Reisberger, M. D.

19 (Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Oct. 13 1924

20 UNDERTAKER John H. Weber — ADDRESS 1803 Bank St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91016

CERTIFICATE OF DEATH.

1047

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Flynn

(a) Residence No. 1044 N. Central St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Flynn

6-DATE OF BIRTH (month, day and year) Jan. 11, 1852

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Jung

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address).....

OCT 1 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-12-24

17- I HEREBY CERTIFY, That I attended deceased from 6-14, 1923, to 10-12, 1924, that I last saw h[illegible] alive on 10-12, 1924, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Chas. G. Flynn, M. D.

10-12 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Cross C. a. Co.	10-14, 1924
20-UNDERTAKER,	ADDRESS
E & B Hasle	115 E. [illegible] St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91017

CERTIFICATE OF DEATH.

60-001

D 91017

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Joseph's Hosp. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M^rs Rossmann

(a) Residence No. 1214 Belmont Ave St., Ward.

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~Sex~~ Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis C Rossmann

6-DATE OF BIRTH (month, day and year) Dec 22 1892

7-AGE. 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Jacob E Buckey Jr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Barbara E Runge

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Louis C Rossmann.

(Address) 1214 Belmont Ave

OCT 31 1924

ROBERT A. KNOTT Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-13-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Oct 13 1924, that I last saw her alive on Oct 13 1924 and that death occurred, on the date stated above, at 3.35 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Thyrotoxicosis II

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exophthalmic goitre

(Duration) yrs. 18 mos. ds.

18-Where was disease contracted if not at place of death? 1214 Belmont Ave

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Aybert M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md. DATE OF BURIAL. 10-16 1924

20-UNDERTAKER. E & B Hasle ADDRESS 115 E Mulberry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 91018

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Norris ST. 19 WARD)

2-FULL NAME Olevia Lewis

(a) RESIDENCE No. 509 N. Norris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1892 - Aug. 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George N. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Denby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George W. Lewis

(Address) 916 Lamb

Filed OCT 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 11, 1924, that I last saw her alive on Oct. 10, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Abcess of the Knee Joint

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayes, M. D.

10/13 1924 (Address) 513 N. Belnont Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 13 1924
20 UNDERTAKER	ADDRESS
Hamilton Chance & Son	1403 Madison

Spec—12-23-21—E.B.R.S.—400 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91019

CERTIFICATE OF DEATH. 74-001

D 91019

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3315 Gwynn Oak Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Lettier

(a) Residence No. 3315 Gwynn Oak Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Lettier

6-DATE OF BIRTH (month, day and year) June 6 1852

7-AGE. 72 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, George W. Fisher

11-BIRTHPLACE OF FATHER (city or town) Hanover (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Emily Holtzman

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country) Md

14- (Informant) John D. Lettier

(Address) 3315 Gwynn Oak Ave

OCT 13 1924

ROBERT K. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Oct 10 1924, that I last saw h-- alive on ..... 19....., and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arterio Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Gorman M. D.

Oct 10, 1924 (Address) 4209 Liberty Hgts

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. Oct 14 1924

20-UNDERTAKER. Veteran Hse ADDRESS 1723 W. Lafayette Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91020

CERTIFICATE OF DEATH. 100-001 D 91020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Broadway ST., 17 WARD)

2-FULL NAME Dorothy Mae Quimby

(a) RESIDENCE NO. 613 Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) July 25th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Maefel Quimby

11 BIRTHPLACE OF FATHER (city or town) Long Green (State or country) Md

12 MAIDEN NAME OF MOTHER Daisy Burton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wakefield Quimby (Address) 613 Broadway St.

15 OCT 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1924, to Oct 11th, 1924, that I last saw her alive on October, 1924 and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows: Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Rickets (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Hughes Story M. D.

(Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 13 1924
20 UNDERTAKER Mrs. R. C. Elliott	ADDRESS 125 Ashland Ave

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91021

CERTIFICATE OF DEATH

129

D 91021

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 ST., WARD)

2-FULL NAME Maggie Postum

(a) RESIDENCE NO. 9 Hampstead Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Poston

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 OCT 13 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 11, 1924, that I last saw her alive on Oct, 11, 1924, and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Chr nephritis

Chr rheumatic endocarditis, mitral stenosis

Myocardial Insufficiency

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute endocarditis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Louis E. Martin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Oct 14 1924

20 UNDERTAKER Chas. H. Johnson — ADDRESS 416 N. Carlton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001

D 91022

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Cathedral & Mulberry - Wentworth Apts.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. O'Brien

(a) Residence No. Cathedral & Mulberry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Doyle

6-DATE OF BIRTH (month, day and year) July 21, 1868

7-AGE.			If LESS than 1 day.
56 yrs.	2 mos.	20 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Buyer

(b) General nature of industry, business, or establishment in which employed (or employer): Retail Dry Goods

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Allegheny, Pa.

PARENTS.

10-NAME OF FATHER, James O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth McDermott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

11- (Informant) Edward O'Brien

(Address) Wentworth Apartments

15-

Filed OCT 31 1924 ROBT. F. KRAUTH Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1923, to Oct. 11, 1924,

that I last saw him alive on Oct. 10, 1924,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Primary Anemia (Pernicious)

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Numerous Blood Examinations

(Signed) Geo. D. Rowe M. D.

Oct. 13, 1924 (Address) 1115 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	10/14, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Myers & Son	805 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

D 91023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 91023

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 830 N Chester St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Fagan

(a) Residence No. 830 N Chester St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 12 24

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 4 hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Fagan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary Ulrich

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) John Fagan

(Address) 830 N Chester St

15- Filed OCT 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 13 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 19 24 to Oct 13 19 24

that I last saw h— alive on Oct 13 19 24

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kyrauch M D

(Address) 847 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL. Oct 15, 1924

20-UNDERTAKER. Frank Eisenbeis ADDRESS 1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR OFFICIAL USE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 129

D 91024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Czaplka

(a) RESIDENCE NO. 27 Church ST., Curtis Bay WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
5	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter Czaplka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Galicia Austria

12 MAIDEN NAME OF MOTHER Sophia Zachatkow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Galicia Austria

14 Informant (Address) 27 Church St

15 Filed OCT 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-12-1924. to 10-13-1924.

that I last saw he alive on 10-13-1924.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) AC Manninger M. D.

10/13/1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Oct 13 1924

20 UNDERTAKER Geo A Gwebster

ADDRESS 1906 Eutaw Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 91025

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 East ST. 5 WARD)

2-FULL NAME Robert Queen

(a) RESIDENCE. No. 504 East ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) John H. Queen 504 East St

OCT 14 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1924, to Oct. 11, 1924, that I last saw him alive on Oct. 11, 1924, and that death occurred, on the date stated above, at 11 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

10-13-1924 (Address) 120 Cresgill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	10. 14 1924

20 UNDERTAKER J. Leon Hall

ADDRESS 703 Dallas

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91026

CERTIFICATE OF DEATH.

104-802

D 91026

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Eberle

(a) RESIDENCE No. 1703 N. Bond ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard J Eberle

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Poole.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rebecca Zeller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard J Eberle (Address) 1703 N Bond St.

15 Filed OCT 4 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 1924 to Aug 9 1924 that I last saw h[illegible] alive on Aug 9 1924 and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilepsis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Sept 19/24

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma I Lindgren M. D.

10/1 1924 (Address) 718 N Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 10 14 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91027. **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH.

179 D 91027

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1719 N. Chapel St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Ruse

(a) Residence No. 1719 N. Chapel st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 15-1898

7-AGE 26 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, August J. Ruse

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt. Co.

12-MAIDEN NAME OF MOTHER, Lucinda Lawson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt Co Md

14- (Informant) John A. Deane

(Address) 1719 N. Chapel St

15- Filed, OCT 4 1924 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 11, 1924.

17- I HEREBY CERTIFY, That I attended deceased from October 23 19 24 to Oct 11 19 24 that I last saw h[illegible] alive on Oct 11 19 24 and that death occurred, on the date stated above, at 1.30 P. M. The CAUSE OF DEATH* was as follows:

Pulmonic Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1507 E. Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery — DATE OF BURIAL, Oct. 14, 1924

20-UNDERTAKER, Geo. L. Ruth — ADDRESS 1735 Hanford

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91028

CERTIFICATE OF DEATH.

90 D 91028

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 780 St Peter ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tracey

(a) RESIDENCE No. 780 St Peters ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Angie Tracey

6 DATE OF BIRTH (month, day, and year) Feb 15-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lucy Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm M Tracey

(Address) 1312 S Caroline St

Filed OCT 14 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1924, to Oct. 12, 1924,

that I last saw ~~him~~ alive on Oct. 11, 1924,

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Boyd M. D.

Oct 13, 1924 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	10-14-1924
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91029

CERTIFICATE OF DEATH.

59-001

D 91029

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Colored Hospital ST., WARD)

2-FULL NAME Infant boy Howard + Mable Carr

(a) RESIDENCE NO. 4202 Evergreen Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13 1924

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Howard L Carr

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mabel E Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Howard L Carr (Address) 4202 Evergreen Ave

15 Filed OCT 14 1924 19.. ROBERT P. KNAUER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 13, 1924, that I last saw h alive on " ", 1924 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Abnormal Head + Spine development in the cervical region

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Dearen, M. D.

10/13 1924 (Address) 3707 Gaither Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Oct 14 1924

20 UNDERTAKER N D Marshall — ADDRESS 353 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21—E.B.R.S.—400 Blks.

D 91030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91030

1-PLACE OF DEATH

Registered No. 24 113

City of BALTIMORE: (No. 1841 Belt Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Neal

(a) Residence No. 1841 Belt Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 8 1924

7-AGE.	If LESS than 1 day,
....yrs. 8 ....mos. 4 ....ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Wm. W. Neal

11-BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Addie R. Piearce

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or Country),

14- (Informant) Mrs. Neal

(Address) 1841 Belt Ave.

15- Filed, 192 ROBERT P. KRAUTER Registrar.

OCT 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-12-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 19 24, to Oct 12, 19 24, that I last saw h. alive on Oct 12, 19 24, and that death occurred, on the date stated above, at 12 30 P. M. The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Whelette M. D.

10/13, 1924 (Address) 1799 William H

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	10/14, 19 24
20-UNDERTAKER,	ADDRESS
J. Frew McCully	130 S. Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9103I. HEALTH DEPARTMENT—CITY OF BALTIMORE D 9103I

CERTIFICATE OF DEATH.

1001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 75 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Johnson

(a) Residence No. 54 St. Fairfield, Brooklyn Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1893

7-AGE. 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jack Williams

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Va.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Va

14-

(Informant) Municipal Hospital Record

(Address).....

15-

OCT 14 1924 192.... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-10-24

17- I HEREBY CERTIFY, That I attended deceased from 10-9, 19.24 to 10-10 19.24

that I last saw h.. alive on 10-10 19.24

and that death occurred, on the date stated above, at 7 10a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pneumococcus Meningitis ?

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Howe M. D.

10-10 192 4 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Zion Ch

DATE OF BURIAL. Oct 14 19.24

20-UNDERTAKER. C. R. Brown & Son

ADDRESS 1058 W. Monroe

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91032 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

'46 D 91032

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Asylum St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Camphor

(a) Residence No. 2345 Stockton Street. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow.

5a-~~If married, widowed, or divorced~~ (HUSBAND of ~~or~~) WIFE of John Camphor

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto Md (State or Country), East Indies

PARENTS

10-NAME OF FATHER, Robert Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Ruth Sowles

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Maryland.

14- (Informant) Hospital Records. (Address) Bay View Hospital

15- (Filed) OCT 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 10-24.

17- I HEREBY CERTIFY, That I attended deceased from September 29 1924 to Oct 10 1924

that I last saw h[e] alive on Oct 10, 1924

and that death occurred, on the date stated above, at 11.55 P.M.

The CAUSE OF DEATH* was as follows:

Epidermoid Carcinoma of Uterus

a Metastasis to broad Ligament

Toxic Psychosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) yrs. mos. 1½ ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No-

What test confirmed diagnosis?

(Signed) Jas. O. Camphor, Jr. Md M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL. Oct 14 1924

20-UNDERTAKER. Mrs Jas. H. Dennis Per T. E. Nelson.

ADDRESS 1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91033

CERTIFICATE OF DEATH.

13 D 91033

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 S 12th St., No WARD)

2-FULL NAME Richard E Hobbs.

(a) RESIDENCE NO. 430 S 12th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 23, March 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Hobbs

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Chase

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Joseph Hobbs.
(Address) 430 S. 12th St.

OCT 14 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to ....., 19....
that I last saw h alive on Oct 11, 1924
and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal
Auto Intoxication

(duration) —yrs. 7 mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) —yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) John R. Oppenheimer M.D.

. 19 (Address) 25 N. Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 14 1924

20 UNDERTAKER Jos C Miller & Son — ADDRESS 2334 Jeffer St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91034

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 Roslyn Ave 15 WARD)

2-FULL NAME. James Edwin Griggs

(a) RESIDENCE NO. (Usual place of abode) 2602 Roslyn Ave ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Griggs

6 DATE OF BIRTH (month, day, and year) Aug 20-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Sea. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John L. Griggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Mary V. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Sarah E. Griggs (Address) 2602 Roslyn Ave

15 Filed OCT 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-19, 1924, to 10-12, 1924.

that I last saw him alive on 10-11, 1924,

and that death occurred, on the date stated above, at 10, a m.

The CAUSE OF DEATH* was as follows:

General. weakening & Starvation due to. Coma. the result of.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral. hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R Fitzpatrick, M. D.

10/14. 1924 (Address) 2806 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct 15 1924

20 UNDERTAKER H E Stephens & Sons — ADDRESS N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91035

CERTIFICATE OF DEATH.

129

D 91035

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables 12 ST. WARD)

2-FULL NAME Mary Catherine Hernecke.

(a) RESIDENCE NO. Home for Incurables WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Carston Hernecke

6 DATE OF BIRTH (month, day, and year): Mch 22 1879

7 AGE: Years 45 Months 6 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry H. Wichna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Herman H. Hernecke

(Address): 321 Catonia. Hamilton

15 Filed OCT 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 12. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23- 1922 to Oct. 12- 1924.

That I last saw her alive on Oct. 12- 1924

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, cardiac failure. Chronic Interstitial Nephritis.

about 5 (duration) yrs. — mos. — da.

CONTRIBUTORY (Secondary): Arteriosclerosis deformans

about 20 (duration) yrs. — mos. — da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis? —

(Signed) J. Brandt Brinup M. D.

(Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 10/15/24

20 UNDERTAKER: H. E. Hughes — ADDRESS: 414 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 91036

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 91036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Druid Hill Ave ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C. S. Ward

(a) RESIDENCE NO. 1119 Druid Hill Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug-10-1919

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
5	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Maggie Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Rosa L. Richardson

(Address) 1119 Druid Hill Ave

Filed OCT 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1924

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1924 to Oct 12, 1924

that I last saw h alive on Oct 12, 1924

and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Mullan, M. D.

(Address) 1230 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 14 1924

20 UNDERTAKER: Samuel J. Grumley

ADDRESS: W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

×90D 91037

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 7800 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mrs Delia W. Herr

(a) Residence No. Mt Hope Retreat St., 2800 Ward Harrisburg Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 0 ds. How long in U. S., If of foreign birth? 53 yrs. 0 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of B. F. Herr

6-DATE OF BIRTH (month, day and year) Sept 26 - 1871

7-AGE, 53 yrs. 0 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Hedgesville (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Jeremiah Tinsler

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), (?)

12-MAIDEN NAME OF MOTHER, Kate McCabe

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), (?)

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Balto Md.

15- ROBERT R. KRAUTER, Registrar.

OCT 14 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12 - 1924

17- I HEREBY CERTIFY, That I attended deceased from May 16th, 1924 to Oct 12 - 1924

that I last saw h.e.r alive on Oct 12, 1924,

and that death occurred, on the date stated above, at 9 A. P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis - abt 1 year

Complicated by Acute Gastro-Enteritis - Colitis abt 1 week -

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Manic Depr. Psychosis

Abt (Duration) 1 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore (?) Md -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

Oct (Signed) Frank J. Hannan, M. D.

13th, 1924 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Harrisburg Penna

DATE OF BURIAL, Oct 14, 1924

20-UNDERTAKER, EWART & MOWEN COMPANY (William F. Mowen, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91038 ✓ 113 D 91038

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Dorsey

(a) RESIDENCE NO. St. Vincents Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

10 NAME OF FATHER Unknown?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 14 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924 to Oct 11, 1924, that I last saw h— alive on Oct 11 - 1924, and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) and vomiting

(duration) ..... yrs. ..... mos. 1½ ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? St Vincents Infants Asylum

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edward H. Keiper, M. D.

10/13, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Oct 13 1924

UNDERTAKER Martin Hurley Sons ADDRESS 1829 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91039
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

D 91039
Registered No.

City of BALTIMORE: (No. 918 E. Madison St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Nixon

(a) Residence No. 918 E. Madison St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William R Nixon

6-DATE OF BIRTH (month, day and year) 1860

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of Industry, business, or establishment in which employed (or employer) Washing and Ironing
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mollie Johnson
(Address) 427 Codman St

15- FILED OCT 14 1924 ROBERT R. KRAUTH
192 Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 13. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1924 to Oct 12 1924 that I last saw h. alive on Oct 12 1924 and that death occurred, on the date stated above, at 12:50 A m. The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Arnold M. D.

Oct. 13, 1924 (Address) 1534 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel cemetery	Oct 15 1924
20-UNDERTAKER.	ADDRESS
Edward Bryson	1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A K S · A

Cor.—1-12-23—M&T—100 Bks.

D 91040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D 91040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orville F Gosnell

(a) RESIDENCE No. 69 Darby Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice A Gosnell

6 DATE OF BIRTH (month, day, and year) Jan 5 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5-5			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Harriett Gosnell
(Address) 69 Darby Ave

15 Filed OCT 14 1924 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the 13th day of Oct. 192 4 and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) thereon find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of femur in auto vehicle accident, struck by street car driven by another.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Sealed) [illegible] Coroner ..... M. D.

Oct. 14 192 4 (Address) 1829 Bus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Cedar and Bradley

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Oct 14 192 4

20 UNDERTAKER CHENOWETH & SON ADDRESS 307 CHESTNUT AVE

AGE should be carefully supplied. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9104 1

100-001

Registered No. D 9104 1

1-PLACE OF DEATH

City of BALTIMORE: (No. 845 Decatur St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Klayman

(a) Residence No. 845 Decatur St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Klayman

6-DATE OF BIRTH (month, day and year)

7-AGE. 72 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Builder

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Abraham Klayman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) B. Klayman

(Address) 845 Decatur st

OCT 14 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 13/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 12, 1924, to Oct 13, 1924, that I last saw h... alive on Oct 13 1924 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) exhaustion & senility

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms etc

(Signed) M. M. Poulton M. D.

Oct 13, 1924 (Address) 221 S Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Levin's M. Carmel	10/14 1924
20-UNDERTAKER.	ADDRESS
Sol Levinson & Bro	1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91042

S-1-22-1-EB-K.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91042

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 553 W. Bath St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jerome Walsh Cooney

(a) Residence No. 553 W. Bath St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year): February 1st 1907

7-AGE. 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Boy F.

(b) General nature of industry, business, or establishment in which employed (or employer): W

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS

10-NAME OF FATHER, Matthew J. Cooney

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Anna P. Walsh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14-

(Informant) M. Matthew J. Cooney

(Address) 553 W. Baltimore St.

Filed OCT 14 1924

ROBERT J. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 13. 1924

17- I HEREBY CERTIFY, That I attended deceased from January 15 1924 to Oct 13 1924

that I last saw him alive on Oct 11 1924

and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(Duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) com

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Auscultation Test.

(Signed) J. M. Dilbert M. D.

Oct 13, 1924 (Address) 624 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral Cem. DATE OF BURIAL, Oct 15, 1924

20-UNDERTAKER: Edward J. Cowan Inc. ADDRESS 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Chatham Rd ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes O. Gunderdorf

(a) RESIDENCE. No. 3808 Chatham Rd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo E Gunderdorf

6 DATE OF BIRTH (month, day, and year) Oct 22 68

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Stephen J Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Geo E Gunderdorf
(Address) 3808 Chatham Rd

OCT 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13- 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 - 1923, to Oct. 13 - 1924, that I last saw h[er] alive on Oct. 12 - 1924, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy + Left Hemiplegia and Nephritis

about 3 years

(duration) yrs. mos. ds.

Pulmonary - Embolism + Thrombosis

CONTRIBUTORY (Secondary) Pneumonia 15 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carlton M Cook, M. D.

Oct 13 1924 (Address) 2719 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 15 1924
20 UNDERTAKER	ADDRESS
W M Routzon	2238 N Smith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91044

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Hare

(a) RESIDENCE NO. 1420 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Hare

6 DATE OF BIRTH (month, day, and year): Oct 15 [illegible]

7 AGE: Years 74 | Months 11 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co. Md

14 Informant: Elizabeth Ziegler

(Address): 1420 W Franklin

15 OCT 14 1924

ROBERT F. KRAUTER, Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-12-1924

17

I HEREBY CERTIFY, That I attended deceased from 10-6-, 1924, to 10-12-, 1924.

that I last saw h[illegible] alive on 10-12-, 1924,

and that death occurred, on the date stated above, at 6[illegible] A m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular disease of heart

Mitral Stenosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. S. Parr, M. D.

10/12, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U S National Cem

DATE OF BURIAL: Oct 14 1924

20 UNDERTAKER: W. M. Routson

ADDRESS: 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91045

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 118 E. Woodland ave (ST.) 27 (WARD)

2-FULL NAME John A. Plowman

(a) RESIDENCE No. 118 E. Woodland ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Clara Plowman

6 DATE OF BIRTH (month, day, and year) Dec 9 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
70	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment in which employed (or employer) P. R.R.

(c) Name of employer P.R.R.

9 BIRTHPLACE (city or town) (State or country) Parkton Md

PARENTS

10 NAME OF FATHER Henry Plowman

11 BIRTHPLACE OF FATHER (city or town) Reynolds (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Kelly

13 BIRTHPLACE OF MOTHER (city or town) Reynolds (State or country) Maryland

14 Informant Geo. T. Plowman

(Address) 118 E. Woodland ave

15 Filed OCT 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Oct. 13, 1924

that I last saw h~~i~~e alive on Oct 13, 1924

and that death occurred, on the date stated above, at 4.10 A m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Paul Brown, M. D.

(Address) 1837 Pa ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Valley Cem.	10/15/1924
20 UNDERTAKER	ADDRESS
M. C. Timms and Carroll	1703 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA furnished mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

D 91046

REGISTERED NO.

1-PLACE OF DEATH Auburn Hospital

CITY OF BALTIMORE: (No. ... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Davis

(a) RESIDENCE NO. 2115 Maryland Ave ST., ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Margaret E Davis

6 DATE OF BIRTH (month, day, and year): Feb 26 1871

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Clover Club

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Benjamin H Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Margarth E Davis 2115 Maryland Ave

15 [illegible]

OCT 14 1924

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1924

17

I HEREBY CERTIFY, That I attended deceased from 9/15, 1922, to Oct 12, 1922

that I last saw h. m alive on Oct 12, 1922

and that death occurred, on the date stated above, at 1.2. m S P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Carcinoma of Kidney & metastasis to liver (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of 9/16

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Darby, Gaston, M. D.

, 19 (Address) Clover Club.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Oct 15 1924

20 UNDERTAKER: W. Cook — ADDRESS: 5028 Auth Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

91047

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 91047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 9 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Frome

(a) Residence No. 2708 Harford Av St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Irma Frome

6-DATE OF BIRTH (month, day and year) March 26-1893

7-AGE, 31 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Ernest Frome

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Annie Hogan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Irma Frome

(Address) 2708 Harford Av

15-Filed OCT 14 1924 ROSLEA M. KINSTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-13-24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12 1924 to Oct. 13 1924

that I last saw him alive on Oct. 13 1924

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Edema of lungs

(Duration) ..... yrs. ..... mos. 1½ ds.

CONTRIBUTORY (Secondary) Uremea

(Duration) ..... yrs. ..... mos. 1½ ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical and laboratory

(Signed) Geo. B. Sybert, M. D.

10, 13, 1924 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct. 17, 1924

20-UNDERTAKER, William Cook — ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, with pen and ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 91048

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2231 Cecil Ave. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida May (Mc Duffee) Pearl

(a) Residence No. 2231 Cecil Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~ Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Frank Pearl

6-DATE OF BIRTH (month, day and year) Apr. 4, 1855

7-AGE. 69 yrs. 6 mos. 10 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Harrington (State or Country) New Hampshire

PARENTS.

10-NAME OF FATHER. Chas. E. McDuffee

11-BIRTHPLACE OF FATHER (city or town) Alton, (State or Country) New Hampshire

12-MAIDEN NAME OF MOTHER Eliza A. Davis

13-BIRTHPLACE OF MOTHER (city or town) New Durham (State or Country) New Hampshire

14-

(Informant) Mayme Pearl

(Address) 401 Hawthorn Road. Balto.

OCT 14 1924

Filed 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/13/24

17- I HEREBY CERTIFY, That I attended deceased from October 1923 to Oct 13 1924

that I last saw h. alive on 10/13 1924

and that death occurred, on the date stated above, at 9 15 P M

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Stebbins M. D

10/13, 1924 (Address) 1403 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Harrington, N. H.	Oct. 16, 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E Madison

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated. OCCUPATION is very important. See should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91049

CERTIFICATE OF DEATH.

90 D 91049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. W. Bra Slaton House Hebrew Home WARD)

2-FULL NAME Jno. D. Daniels.

(a) RESIDENCE No. 615 W. Mulberry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 10-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Harry Papas

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Stavros Saurls

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Harry Papas
(Address) Lombard & Lombard Sts.

15 Filed OCT 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) T. H. Gonzales, M. D.
(Coroner.)

10-13, 1924 (Address) 117 N. Gay St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct. 14 1924
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1427 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91050

CERTIFICATE OF DEATH.

100-001

D 91050

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Samuels

(a) RESIDENCE NO. Stone House Cove, Curtis Bay ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See Instructions on ba

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Hadan Samuels

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Cronstaunty

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant (Address) Matilda Samuels Stone House Cove Md

15 Filed OCT 14 1924, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, , 1924, to Oct. 13, , 1924, that I last saw him alive on Oct. 13, , 1924, and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Pyloric Stenosis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Oct. 12, 1924.

Was there an autopsy? Yes - Makes the Stenosis

What test confirmed diagnosis? Operation and autopsy

(Signed) Raymond T. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Oct 16 1924

20 UNDERTAKER Margaret E. Flynn

ADDRESS 14 W Preston St

Spec.—1-10-21—M&T—1500 Bks.

D 9105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-007

D 9105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD 10)

2-FULL NAME Joseph Walsh

(a) RESIDENCE NO. 416 E. Chase St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Isabelle G. Bouchet

6 DATE OF BIRTH (month, day, and year) Jan. 27 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Auditor

(c) Name of employer Maryland Casualty Co.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Molloy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hughes Reard

(Address)

15 Filed OCT 14 1924 ROBERT E. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/24

17 I HEREBY CERTIFY, That I attended deceased from 9/20/24, 19..., to 10/13/24, 19... that I last saw h-- alive on 10/13/24, 19... and that death occurred, on the date stated above, at 4.00 a. m.

The CAUSE OF DEATH* was as follows:

Atypical Cirrhosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of 10/11/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Chemical

(Signed) H. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 10/15 19 24

20 UNDERTAKER: Henry W. Myers & Son — ADDRESS: 805 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91052 12/9 D 91052

CERTIFICATE OF DEATH.

D 91052 1-PLACE OF DEATH Orphans Court Rear of

Registered No.....

City of BALTIMORE: (No. 1918 Aliceanna St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kissner

(a) Residence No. 1918 Aliceanna St., 2 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Charles Kissner

6-DATE OF BIRTH (month, day and year) Oct. 20th 1850

7-AGE, 73 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Samuel Ott.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant). Charles Kissner
Res. (Address). 1918 Aliceanna St.

OCT 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 19 24 to Oct 11 19 24

that I last saw h[illegible] alive on Oct 11 19 24

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Henry Smiley M. D.

10-12-24 (Address) 1938 E. Oxford

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL, Oct 15 19 24

20-UNDERTAKER. Lilly + Zeiler — ADDRESS 4033 S. Wolfe

N. B.—WHITE CERTIFICATES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91053 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91053

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1432 N. Patterson Park St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry T. Kershaw

(a) Residence No. 1432 N. Patterson Park ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kershaw

6-DATE OF BIRTH (month, day and year) April 21, 1865

7-AGE 59 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Traveling Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Kershaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Eliza Theban

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md.

14- (Informant) Mary Kershaw

(Address) 1432 Patterson Park ave

15- Filed OCT 14 1924 H. A. M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 12, 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Oct 12, 1924

that I last saw him alive on Oct 12, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma B. Lemmon M. D.

10/13, 1924 (Address) 718 N. Patterson Park

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL. Oct 15, 1924

20-UNDERTAKER. Zickler & Zickler — ADDRESS 1739 Eager st

N. B.—WHITE PAPER for RECORDS. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter on file Oct 15-1924.)

D 91054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91054

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp. ST. 23 WARD) Daisy Virginia B

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Goldsborough

(a) RESIDENCE No. 911 Bevan St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	1	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Hattie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant Mother
(Address)

15 Oct 15 1924, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Oct 13, 1924, that I last saw he alive on Oct 13, 1924, and that death occurred, on the date stated above, at 6 55 p m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 33 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Hosp. md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Sull, M. D.

, 19 (Address) Sydenham Hosp. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity

DATE OF BURIAL Oct 15 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE ... should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T1 4 15324

Spec—12-23-21—E.B.R.S.—400 Bks.

1924 C 2 1857

D 91055

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 91055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Box 78 Georgetown Rd, St. Morrell Park Ward) 129

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Marion C. Knight

(a) Residence No. Box 78 Georgetown Rd St., Morrell Park Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie Knight

6-DATE OF BIRTH (month, day and year) / 1857

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Expressman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER, Jacob Knight

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Helen McCaland

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Mrs Annie Knight

(Address) Box 78 Georgetown Rd Morrell Park

15- Filed ..... 192 ..... Registrar.

OCT 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 13th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Oct 13, 1924, that I last saw h... alive on Oct 13, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo Smith Geer M. D.

Oct 13 1924 (Address) 2320 Back River Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Am. DATE OF BURIAL, Oct 15th 1924

20-UNDERTAKER, George J Schilling & Sons ADDRESS 1262 Monument

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91056

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Sampson

(a) Residence No. 3321 Hudson St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Sampson

6-DATE OF BIRTH (month, day and year) 1859

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country),

PARENTS.

10-NAME OF FATHER, Adolph Hoffman

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ....., 192.

Robert P. Harrison, Registrar.

CT 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-13-24

17- I HEREBY CERTIFY, That I attended deceased from 3-17, 1924, to 10-13, 1924, that I last saw h[illegible] alive on 10-13, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude C. Howe, M. D.

10-13, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Pasture Cem. DATE OF BURIAL, Oct 16th, 1924

20-UNDERTAKER, Tilly and Zile ADDRESS 1033 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 91057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91057

47

1-PLACE OF DEATH

City of BALTIMORE: (No. 873 S. Third St. St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Miller

(a) Residence No. 873 S. Third St. St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Miller

6-DATE OF BIRTH (month, day and year) Sept 29-1873

7-AGE. 51 yrs. 0 mos. 15 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Zoeberlein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Apolonia Kuhn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) James Clark

(Address) 873 S. Third St.

15- Filed OCT 14 1924 19 Robert J. Barton Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 13-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 19 24 to Oct 13 19 24

that I last saw her alive on Oct 12 19 24

and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right Breast

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Malastasis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 2 1924

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Horace P. Tilden M. D

10/14, 1924 (Address) 310 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Most Holy Redeemer — DATE OF BURIAL. Oct. 16 19 24

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

OCT 14 1924

N. B.—WHITE PEARL, WITH BLACK INK should be used. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91058

D 91058

CERTIFICATE OF DEATH.

6 49

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 133 N. Lemwood Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Cole

(a) Residence No. 133 N Lemwood Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of C. Wallace Cole

6-DATE OF BIRTH (month, day and year) Feb. 28-1860

7-AGE. 64 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Andrew J. Sapp.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Sarah J. Wright.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) C. Wallace Cole

(Address) 133 N. Lemwood Ave

15-

Filed OCT 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 13-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924 to Oct 13, 1924

that I last saw h.. alive on Oct 13, 1924

and that death occurred, on the date stated above, at 4.00 A. m.

The CAUSE OF DEATH* was as follows:

E Lansdowne

(Duration) yrs. Few mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

Bladder (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Richardson M. D.

Oct 14 1924 (Address) 1710 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oak Lawn Cem.	Oct. 15th 1924

20-UNDERTAKER,	ADDRESS
Lilly & Zeile	403 S. Wolfe

NOTICE—Entries must be printed EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500-Bks.

D 91059 2 — D 91059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Frank L Fitzig

(a) RESIDENCE NO. 718 W Hemingway ST. ..... WARD Dubuque Iowa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. — mos. 9 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dubuque Iowa
(State or country)

PARENTS

10 NAME OF FATHER John Fitzig

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Hafka

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 14 1924, 19 Robert P. Garrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 1924 to Oct 11 1924, that I last saw him alive on Oct 11 5 1924, and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor - malignant

(duration) x yrs. 3 mos x ds.

CONTRIBUTORY (Secondary)

None (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 9-24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Thos Halsted M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dubuque Iowa — DATE OF BURIAL: Oct 14 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS and state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See Instructions on back of certificates. OCCUPA-

OCT 14 1924

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91060

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 662 Portland St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anne Tighe

(a) Residence No. 662 Portland St., 22 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-~~If married, widowed, or divorced~~ HUSBAND ~~of~~ (or) ~~WIFE~~ of John B. Tighe

6-DATE OF BIRTH (month, day and year) May 12 1863

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant) John B. Tighe

(Address) 662 Portland St

15-Oct 13 1924 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 12

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 19 24 to Oct 12 19 24

that I last saw him alive on Oct 11 19 24

and that death occurred, on the date stated above, at 4 o. a.m.

The CAUSE OF DEATH* was as follows:

Congestion of the Lungs

over

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Boyd M. D

Oct 13 1924 (Address) 662 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 10/15 19 24
St Peters Cemetery	
20-UNDERTAKER, Geo Lennbuhler	ADDRESS 647 W Pratt St

41924

WHITE PLAINLY, WRITING INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9106F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9106F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Willax Ave (Lauraville) St., 27 Ward) 44

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Doris Kramer

(a) Residence No. 7 Willax Ave (Lauraville) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis W. Kramer Sr

6-DATE OF BIRTH (month, day and year) July 16 1868

7-AGE, 58 yrs. 2 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9-BIRTHPLACE (city or town): Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Nordmeier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Doris Grote

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louis W. Kramer Sr.

(Address) 7 Willax Ave (Lauraville)

15- Filed 192 Robert P. Harrison, Registrar.

CT 1 41924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 24, to Oct 12 19 24 that I last saw h alive on Oct 12, 19 24 and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage into Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach (Duration) yrs. mos.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) Chas Bonnin, M. D.

10/13, 1924 (Address) 4 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Dulaneys Park Cem	Oct 15 1924
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 W Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91062

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 81 Columbia Ave. Raspeburg St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....John B. Young.....

(a) Residence No.....81 Columbia Ave. Raspeburg St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 3, 1876

7-AGE, 48 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Helper (Steam 060

(b) General nature of industry, business, or establishment in which employed (or employer) Fitter-General Electric Company

(c) Name of employer.....

9-BIRTHPLACE (city or town).....Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Charles A. Young

11-BIRTHPLACE OF FATHER (city or town) Frederick
(State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Rebecca Bert

13-BIRTHPLACE OF MOTHER (city or town) Chambersbourg
(State or Country) Pennsylvania

14- (Informant) Mrs. W.R.Maggio

(Address).....81 Columbia Ave. Raspeburg

15- Filed....., 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CT 14 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 19 24, to Oct 12, 19 24

that I last saw h.....alive on Oct 11, 19 24,

and that death occurred, on the date stated above, at 7 P.....m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Toxaemia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Cancer of Stomach (Secondary) .....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

10-1-24 (Signed) Chas Young, M. D.

, 19 2 (Address) 4706 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL, Oct 15 1924

20-UNDERTAKER: Joseph B Cook — ADDRESS 1003 N Eutaw St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

oc—12-23-21—E.B.R.S.—400 Bks.

D 91063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91063

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3410 Philadelphia Ave No St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian E. Stenger

(a) Residence No. 3410 Philadelphia Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 23. 1902

7-AGE, 21 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerical work
(b) General nature of industry, business, or establishment in which employed (or employer) Grief Bros
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James B. Stenger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Clara A. Sauer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Haven Conn

14- (Informant) James B. Stenger
(Address) 3410 Philadelphia Ave.

15- Oct 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 11/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 19..., to Oct 11, 19..., that I last saw h[illegible] alive on Oct 11, 19..., and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis Florida

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Edema Lungs

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James G. Slade, M. D.

(Address) 4376 Penn Ave

*State the disease causing death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Conn — DATE OF BURIAL, Oct. 15, 1924

20-UNDERTAKER, Mr & Mrs John V. Teufel & Son — ADDRESS 847 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91064

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 Madison Ave. ST., 13 WARD)

2-FULL NAME Sareh Rosenheim

(a) RESIDENCE NO. 2508 Madison Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leopold Rosenheim

6 DATE OF BIRTH (month, day, and year) July 27, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Fried

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Getz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mr. J. Rosenheim
(Address) Richmond, Va.

15 OCT 14 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/24 19

17

I HEREBY CERTIFY, That I attended deceased from Aug 2 1/2, 19 24, to Oct 13, 19 24,

that I last saw h[er] alive on Oct 13, 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Myocarditis Senilis

(duration) 18 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation, Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) H. Friedenwald, M. D.

Oct 14 19 24 (Address) 1516 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 10/15/24 19

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91065

CERTIFICATE OF DEATH.

90

D 91065

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 1509 N. Durham (St.:) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F School

(a) RESIDENCE. (No.) 1509 N. Durham St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced (write the word)
F.	W	W.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm H. School.

6 DATE OF BIRTH (month, day, and year) Aug 11th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Lim Gray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hennie Blackburn.
(Address) 1509 N Durham St

15 Filed OCT 14 1924 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-1924

17 I HEREBY CERTIFY, That I attended deceased from 8-1- 1924 to 10-12 1924

that I last saw her alive on 10/12 1924

and that death occurred, on the date stated above, at 3P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible], M. D.

19 (Address) 800 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Oct 15th 1924
20 UNDERTAKER	ADDRESS
Leo G. Cook	North Milford Ave

OCT 14 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91066

CERTIFICATE OF DEATH.

D 91066

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

REGISTERED NO. 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Irene Campbell

(a) RESIDENCE No. 1739 Montpelier St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Campbell

6 DATE OF BIRTH (month, day, and year) June 11/1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John W. Kinzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Beatrice Kelly
(Address) 1214 N. Bradford

15 Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull (Base)
Automobile Accident

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Kalb, M. D.
(Coroner.)

10/14/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemty — DATE OF BURIAL Oct 16 1924

20 UNDERTAKER Robt J Turner Jr — ADDRESS 1343 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. FIGURES must be used that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91067

CERTIFICATE OF DEATH.

74-001

74 D 91067

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 S. Sharp St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Gross

(a) Residence No. 810 S Sharp St., 22 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marjorie Gross

6-DATE OF BIRTH (month, day and year) 1877

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Levedge

(c) Name of employer. Lowell Paint Co.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Gross

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Marjorie Gross

(Address) 810 S Sharp St

OCT 5 1924

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/3/24

17- I HEREBY CERTIFY, That I attended deceased from 10/1/24 to 10/3/24

that I last saw h... alive on 10/3/24

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Fat Degeneration of Heart

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

10/4, 1924 (Address) 910 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL, Oct 15 1924

20-UNDERTAKER. John H. Toadvine & Sons

ADDRESS 1027 Hull St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Julius Jacobson

D 91068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1819 Pressman St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Jacobson

(a) RESIDENCE NO. 1819 Pressman St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Jacobson

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Expressman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Alexander Jacobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Max Solmson

(Address) 1819 Pressman St.

Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/24 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 11 24, 19, to Oct 15 24, 19, that I last saw h alive on Oct 15 19 24 and that death occurred, on the date stated above, at 1 AM m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Primary) (Immediate) Angina Pectoris (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. E. Hawk M. D.

Oct 3, 19 24 (Address) 4 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 10/15/24 19

20 UNDERTAKER David Sonnheim

ADDRESS 115-20 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-B 91069

D 91069

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Hosp. for Women of Md.

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robinson

(a) RESIDENCE NO. ..... Lutherville Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE BLANKS should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 16 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William Robinson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Flora Powers

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) R. Island

14 Informant W. H. Robinson
(Address) Lutherville Md

15 Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1924, to ....., 19..., that I last saw him alive on Oct. 14, 1924, and that death occurred, on the date stated above, at 9 40 P m.

The CAUSE OF DEATH* was as follows:

Prematurity - 9½ months

JRBrus.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature rupture of membranes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. W. S. Murray M. D.

Oct 14, 1924 (Address) 1101 Saint Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonds Cemetery	14 1924
20 UNDERTAKER	ADDRESS
Wm Burns Sons	Towson

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91070

100-001

CERTIFICATE OF DEATH.

D 91070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lamb's Baltd Hosp. ST., 4 WARD)

2-FULL NAME Harry Dogge (or Milan)

(a) RESIDENCE NO 416 N. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. — mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian R. Dogge

6 DATE OF BIRTH (month, day, and year) Sept 22 '76

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Tinner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert Dogge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Albert Dogge (Address) Glenburnie Md

15 Filed OCT 15 1924 ROBERT R. KRAUTEN, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gunshot

Fracture of Cranium - Contusion of brain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) M. Riley (Coroner.) M. D.

Oct 14, 1924 (Address) 763 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death ....yrs., ...mos., ...ds. In the State Gunshot yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Mem Co. DATE OF BURIAL Oct 15 1924

20 UNDERTAKER John F Denny ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should so CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9107 D 9107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital REGISTERED NO. 936

CITY OF BALTIMORE: (No. Raynor ave and Dukeshire ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby King

(a) RESIDENCE NO. 1900 Linden av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. Hr. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Balto Gen Hospital

PARENTS

10 NAME OF FATHER William King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Miss Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant

(Address)

15 Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from October 12, 1924, 11:30 pm to October 13, 1924, 1:30 am

that I last saw him alive on October 13, 1924,

and that death occurred, on the date stated above, at 12:30 am.

The CAUSE OF DEATH* was as follows:

premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clement L. Monroe, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Balto Gen Hosp DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

Commissioner of Health.

OCT 14 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

314

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91072

CERTIFICATE OF DEATH.

3/5 D 91072

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3110 Montebello ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Crate

(a) Residence No. 3110 Montebello ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 16th 1887

7-AGE, 37 yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Henry Crate

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Sophia R Stein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14-(Informant): Mrs. Ida M. Crate

(Address): 3110 Montebello ave

15-Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 14th 1924

17-I HEREBY CERTIFY, That I attended deceased from August 5th, 1924, to Oct 14th, 1924, that I last saw ... alive on Oct 13th, 1924, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jno W Humphrey M.D.

19-(Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Oct 18th 1924
20-UNDERTAKER,	ADDRESS
George Schluraff Sons	1126 E Monument St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Carman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91073

CERTIFICATE OF DEATH.

90 D 91073

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 mc Culloh St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Carman

(a) Residence No. 909 mc Culloh St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Carman

6-DATE OF BIRTH (month, day and year) June 6 1889

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown.

14-

(Informant) Mrs Carman

(Address) 909 mc Culloh St

OCT 15 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 18, 1924 to Oct 12, 1924

that I last saw h[illegible] alive on Oct 11, 1924

and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) H K Carey M. D.

, 19 (Address) 1317 Eastern

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) **whether Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Oct 16, 1924
20-UNDERTAKER.	ADDRESS
Mrs. R. A. Elliott	1725 Eastern Ave

N. B.—WRITE PLAINLY with pen and ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILM TEST

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91074

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edward James Tobler,

(a) Residence No... Preston & Valley Sts. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elizabeth Purcell

6-DATE OF BIRTH (month, day and year) March

7-AGE 75 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired MD

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Tobler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Wiesmiller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Miss Anna Graney

(Address) 61 E. Lafayette St.

15- Filed OCT 15 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 19.. to ....., 19.....,

that I last saw h... alive on Oct 5, 1924

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ....yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Debility of age

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death?... Date of...

Was there an autopsy?...

What test confirmed diagnosis?...

(Signed) F. A. Warner, M. D.

Oct 14, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Peters	Oct 16, 1924
20-UNDERTAKER, E. A. Kreafeld	ADDRESS 501 E 32 St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY. WITH UNFADING INK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 91075

REGISTERED NO. C 14001 D 91075

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1638 W. Baltimore St. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of Street and number and fill out No. 18.)

2-FULL NAME Sarah L. Slacum

(Residence in Baltimore: No. 1638 W Baltimore St.: 12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	married

6-DATE OF BIRTH March 7, 1842 (Month) (Day) (Year)

7-AGE 82 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER William Robbins

11-BIRTHPLACE OF FATHER (State or country) Virginia

12-MAIDEN NAME OF MOTHER Polly Forrest

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth W. Nixon

(Address) 1638 W. Balto St.

15

OCT 15 1924 ROBERT R. KRAUTER REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct 14th, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1923, to Oct 14 1924 that I saw h[illegible] alive on Oct 12, 1924 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Arterio - Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Samuel Steinberg M. D.

Oct 14, 1924. (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. d

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cambridge Md

DATE OF BURIAL Oct 16, 191

20-UNDERTAKER William Cook

ADDRESS 502 E North

Cor.—1-12-23—M&T—100 Bks.

D 91076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Fr Riley

1924 D 91076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

2-FULL NAME John Gustafsson

(a) RESIDENCE No. 635 North Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Gustafsson

6 DATE OF BIRTH (month, day, and year) Aug. 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer) Helper
(c) Name of employer E. J. Crook & Co

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Annie Gustafsson
(Address) 635 N. Calvert Street

15 OCT 15 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of abdomen Homicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) [illegible], M. D.
Oct 14, 192 (Coroner) (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., 2 mos., ...ds. In the State ....yrs. ....mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence 635 N. Calvert St

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 15 1924
20 UNDERTAKER	ADDRESS
Truman Cook	502 E North

NOTE—NAME PLAINLY; ALL QUESTIONS should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stec—12-23-21—E.B.R.S.—400 Bks.

D 91077 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 Gorsuch Ave St., 9 Ward) Registered No. 129

2-FULL NAME Sarah E Riston

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 800 Gorsuch Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm Riston

6-DATE OF BIRTH (month, day and year): Dec 11/848

7-AGE: 75 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Co Md

PARENTS.

10-NAME OF FATHER: Wm Corns

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Co. Md.

12-MAIDEN NAME OF MOTHER: Catherine Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Co. Md

14-(Informant): Miss Katie Riston
(Address): 800 Gorsuch ave

15-Filed OCT 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 13/924

17- I HEREBY CERTIFY, That I attended deceased from last 6 mo. 19.... to Oct 13 19 24

that I last saw h.r alive on Oct 13 19 24

and that death occurred, on the date stated above, at 8 45 p m

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

about 10 hours (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Several (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? usual

(Signed) G. Latrobe Ewalt M. D.

10/14, 1924 (Address) 2945 St. Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Oct 17 1924

20-UNDERTAKER: John F Denny — ADDRESS: 715 Light St

N. B.—WHITE PENCIL MARKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

D 91078

D 91078

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial St. Hosp. WARD)

2-FULL NAME Baby John Jacob Ries

(a) RESIDENCE NO. 1446 Carroll ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-10-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Casper Ries

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Lulu Brady

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mother - see above (Address)

OCT 15 1924

ROBERT SOKRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-2 , 1924 , to 10-14 , 1924 ,

that I last saw him alive on 10-14-24 , 19

and that death occurred, on the date stated above, at 2 00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edwin D. Jarrett, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	OCT 17 1924
20 UNDERTAKER Dept. of Health.	ADDRESS
Per. Wm. E. Woodall	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91079 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 B 001

D 91079

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1207 John ST., 11 WARD)

2-FULL NAME Howard Bruce Ebaugh

(a) RESIDENCE No. 1207 John ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ellis Ebaugh

6 DATE OF BIRTH (month, day, and year): Mar 15 1864

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanical Eng.

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hampstead Carroll Co

PARENTS

10 NAME OF FATHER: Joseph Ebaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Carolyn Weir

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Mary E Ebaugh 1207 John St

15 Filed ..... 19 ..... Burial Permit Clerk

Registrar

OCT 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 14, 1924, that I last saw him alive on Oct 13, 1924, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy. (duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis. (duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bonn and Kind, M. D.

10/15 1924 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Oct 16 1924

20 UNDERTAKER: Wm J Pickerdons — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE FOR RECORDING OFFICIAL INFORMATION. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D 91080

CERTIFICATE OF DEATH.

D 91080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 Woodbrook Ave ST. 13 WARD)

2-FULL NAME Annie M. Markert

(a) RESIDENCE NO. 2813 Woodbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 8 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A. Markert

6 DATE OF BIRTH (month, day, and year): Feb. 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Robert Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Maria Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Wm A. Markert.

(Address): 2813 Woodbrook Ave

15 Filed OCT 15 1924 19.... Registrar

ROBERT A. KRAUSE
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1924

17

I HEREBY CERTIFY, That I attended deceased from January, 19.., to Oct 13, 19.24.

that I last saw her alive on Oct 10, 19..

and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 3 yrs. 9 mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. K. Duvall, M. D.

(Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 15 24
20 UNDERTAKER: Wm J Lichtner & Sons	ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS DATA WILL BE USED FOR STATISTICAL PURPOSES ONLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 9108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 9108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Camilla Billmyer

(a) RESIDENCE NO 920 Madison Ave St., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	about 55	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry H. Mackey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Schmitter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant David Billmyer

(Address) 4728 Pimlico Road

15 Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) Wm. E. Hoffman, M. D.
(Coroner.)

Oct 14th 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Oct 16 1924

20 UNDERTAKER Wm J. Tickner & Son

ADDRESS York Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91082

CERTIFICATE OF DEATH.

D 91082

5-8-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3221 E. Baltimore St., No Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Madeline Lunzeman

(a) Residence No. 3221 E. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE. 19 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Fred Lunzeman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): City

12-MAIDEN NAME OF MOTHER: Catherine Krenchaffer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): City

11- (Informant) Cath. L. Lunzeman

(Address) 3221 E. Baltimore St.

OCT 15 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 14/24

17- I HEREBY CERTIFY, That I attended deceased from July 25 19 24 to Oct. 14 19 24

that I last saw h[illegible] alive on Oct 13 19 24

and that death occurred, on the date stated above, at 7 55 M.

The CAUSE OF DEATH* was as follows:

Cer Anemia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical Co

What test confirmed diagnosis?

(Signed) G. E. Brades, M. D.

(Address) 1143 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemt. DATE OF BURIAL, Oct. 15th 19 24

20-UNDERTAKER: J. J. Moran ADDRESS 300 E. Balto.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Robinson

D 91083

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 91083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Allen Robinson

(a) RESIDENCE No. 419 N Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Linen plaiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James R. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex W Va.

12 MAIDEN NAME OF MOTHER Marion Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lockton N. J.

14 Informant (Address) James Robinson 419 N Gilmor

15 Filed OCT 15 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to Oct 13, 1924.

that I last saw alive on Oct 13, 1924,

and that death occurred, on the date stated above, at 11.15 m.

The CAUSE OF DEATH* was as follows:

1 Bronchial Pneumonia

2 Am complicated

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Gaskey, M. D.

, 19 (Address) 1618 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Oct 15 24

20 UNDERTAKER Edmund D Hursley ADDRESS 1128 N Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

Wasiljov

D 91084 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1126 Hillman St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Baby Wasiljov

(a) Residence No..... 1126 Hillman St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) 10-14-24

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 1 hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Wasiljov

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Prga Slavia

12-MAIDEN NAME OF MOTHER, Maria Adam

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Prga Slavia

11- (Informant) John Wasiljov

(Address) 1126 Hillman St

OCT 15 1924

Filed ..... 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-14-24

I HEREBY CERTIFY, That I attended deceased from Oct 14 1924 to Oct 14 1924.

that I last saw h[illegible] alive on Oct 14 1924

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J. H. Schumann M. D.

, 19 (Address) 1192 W Lan Bar

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross a a Co	10-15, 19 24
20-UNDERTAKER.	ADDRESS
E & B Hardt	115 E Lan Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks. 1622 W. North Ave.

91085 HEALTH DEPARTMENT—CITY OF BALTIMORE 91085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1635 N. Broadway St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellerson H. Dix

(a) Residence No. 1635 N. Broadway St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): July 17, 1870

7-AGE. If LESS than 1 day. 54 yrs. 7 mos. 26 ds. ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer): Huba Fertilizer Co

(c) Name of employer: Garrett Bldg

9-BIRTHPLACE (city or town) (State or Country): Hoboken N. J.

PARENTS.

10-NAME OF FATHER: John W. Dix

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Mary A. Ellerson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant) Mary A. Dix
(Address) 1635 N. Broadway

15- Filed OCT 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1924 to Oct 13, 1924

that I last saw him alive on Oct 13, 1924

and that death occurred, on the date stated above, at 11.20 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver — 6

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Patient Asylum of State

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gamp M. D.

10/15, 1924 (Address) 6 W. Mt. Vernon Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Olivet Cem.	Oct. 16, 1924
20-UNDERTAKER, H. Sander Sons	ADDRESS 1310 Park Ave

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91086

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002

D 91086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1931 Eutaw Place St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Healy.

(a) Residence No. 1931 Eutaw Place St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): March 17 1857

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James E. Healy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Florinda Onion

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Mrs Chas E. Lauer

(Address) 458 Hanover Ave Glen Burnie Md.

13- Filed OCT 15 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 14, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 19 24 to Oct 14 19 24

that I last saw her alive on Oct 14 19 24

and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

about 5 yrs. mos. ds. (Duration)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) H. C. Pole, M. D.

, 19 (Address) 2034 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Mount — DATE OF BURIAL, Oct 16, 1924

20-UNDERTAKER: John O. Mitchell — ADDRESS 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91087

60-002 D 91087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME John S. Lemen

(a) RESIDENCE No. 20 Augusta ave. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary M. Lemen

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Post Office Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berkley Co, West Va.

PARENTS

10 NAME OF FATHER Nicklass Lemen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berkley Co. West Va

12 MAIDEN NAME OF MOTHER Jennie Shoop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant (Address) John S. Lemen 20 Augusta Ave

15 Filed OCT 15 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/6/24 ....., 19..... to 10/14/24 , 19 ,

that I last saw h[illegible] alive on 10/14/24 , 19 ,

and that death occurred, on the date stated above, at 4 55 a. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 15 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/11/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) R. W. McGregor, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Williamsport Md	Oct 15 1924

20 UNDERTAKER	ADDRESS
Harry A. Witzke	1531 W. Lemmon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91088

CERTIFICATE OF DEATH.

90 D 91088

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2443 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond M. Glacken

(a) Residence No. 2443 N. Charles St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 60 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Port Deposit
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ------- Glacken

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Indiana Yarnall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Miss Elizabeth Yarnall
(Address) 1229 N. 53d. St. West Phila.

OCT 15 1924

Filed ..... 192.....

ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 13 1924

17- I HEREBY CERTIFY, That I attended deceased from October 6, 1924 to October 13 1924 that I last saw h.im alive on Oct 13, 1924 and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2923 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL, 10/15, 19 24

20-UNDERTAKER Henry W. Myers & Son

ADDRESS 805 N. Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91089 (1) D 91089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 1912 W. Lexington St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginia Musgrave

(a) RESIDENCE No. 1912 W. Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3, 1854

7 AGE — Years: 70 — Months: 7 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Stewart & Jackson

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Caleb Musgrave

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Miss Frances Musgrave

(Address) 1912 W. Lexington St.

OCT 15 1924

Date Filed

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Oct 15, 1924.

that I last saw h e alive on Oct 15, 1924

and that death occurred, on the date stated above, at 1.55 a m.

The CAUSE OF DEATH* was as follows:

Ptomain Poisoning

(acute Gastro intestinal autointoxication) (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Martin E. Lindeman, M. D.

(Address) 2002 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION/REMOVAL: London Park — DATE OF BURIAL: Oct. 17 1924

20 UNDERTAKER: Wm Strickenberger — ADDRESS: Rockville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dec

D 91090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91090

CERTIFICATE OF DEATH.

126

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes B Kerr

(a) Residence No. 812 E. 20th St. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or WIFE of) Marion A. Kerr

6-DATE OF BIRTH (month, day and year) 1873

7-AGE 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Jeremiah Casey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary Logan

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Ireland

14- (Informant) Marion A. Kerr

(Address) 812 E. 20th St.

15- OCT 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 19 24 to Oct 14 19 24

that I last saw her alive on Oct 14 19 24

and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Pulmonary embolism

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Mesenteric tumor

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 6/24

Was there an autopsy? No

What test confirmed diagnosis? Clin and Phys. Lab

(Signed) Geo D. Hyslop M. D.

10/14, 1924 (Address) St. Joseph Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Richland Cemetery

DATE OF BURIAL, 10/15 19 24

20-UNDERTAKER Chas. E. Traustow

ADDRESS 1111 Royalton Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91091 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91091

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 W. Franklin ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Samples

(a) RESIDENCE NO. 1615 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daniel Easton

(Address) 716 Penna ave

15 Filed OCT 15 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 19 24, to Oct. 13, 19 24, that I last saw her alive on Oct. 13, 19 24, and that death occurred, on the date stated above, at 8:32P m.

The CAUSE OF DEATH* was as follows:

Nephritis

Uraemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. White, M. D.

, 19 (Address) 1115 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MtAuburn Cem	10/16/24
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

8.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4633 Old Pimlico Road St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Tressa Louise Macneal,

(a) Residence No. 4633 Old Pimlico Road St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Charles L. Macneal,

6-DATE OF BIRTH (month, day and year) October 10. 1897

7-AGE,	If LESS than 1 day,
27 yrs. — mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER John T. Schole,

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER, Mary E. Lyons,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md.

14- (Informant) Charles L. Macneal,
(Address) 4633 Old Pimlico Road

15- Robert P. Harrison, Registrar.

OCT 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) OCT 14 1924

17- I HEREBY CERTIFY, That I attended deceased from May 8 1923 to Oct 14 1924, that I last saw h[illegible] alive on Oct 14 1923 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows: Chronic Pulmonary Tuberculosis

Duration: Unknown

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Penn Manor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Aspiration

(Signed) W. R. Ingram M. D.

19 (Address) 24 Ivy N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL OCT 17 1924 19....

20-UNDERTAKER. Geo W. Little ADDRESS 2769 Edmondson Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and UNDERTAKERS are requested to write plainly and in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1750 91093 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91093

CERTIFICATE OF DEATH. x38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ST., 7 WARD)

2-FULL NAME Vernon Johnson

(a) RESIDENCE NO. Chase Maryland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 38 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Care taker

(b) General nature of industry, business, or establishment in which employed (or employer): Store

(c) Name of employer Mr. Wiseltle

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Nathan Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Mary Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 FILED OCT 15 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 - , 1924, to Oct 13 - , 1924, that I last saw h[illegible] alive on Oct 13 - , 1924, and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Intra-venous Neo-Arsphenamen injection

(over)

Immediate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James Cullum Wareham M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mass MC Church — DATE OF BURIAL: Oct 16 1924

20 UNDERTAKER — ADDRESS

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK. Every question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91094 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91094

413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Chestnut Hill Ave ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenie I. Niegel

(a) RESIDENCE NO. 503 Chestnut Hill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? 20 yrs. 6 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 968

(b) General nature of industry, business, or establishment in which employed (or employer) Play ground

(c) Name of employer association

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. W. C. Niegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eugenie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo W. C. Niegel
(Address) 503 Chestnut Hill Ave

15 OCT 15 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 15 1924, that I last saw h[illegible] alive on Oct 14, 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Staphlococcus septicemia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Furuncle on neck

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Dr Bernard Wirth, M. D.

(Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 17, 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1914 W. Northern

C. & B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91095

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp 20 WARD) 7

2-FULL NAME Mr Frederick W. Roerentrop.

(a) RESIDENCE NO. 1913 W Fayette St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura L. Roerentrop

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1859

7 AGE — Years: 65 — Months: — — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Expert Accountant (self)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frederick Roerentrop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Muhe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant (Address): Colonial Hospital Records 1122 N. Mount Street

15 Filed OCT 15 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CT 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 15 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-2, 1924, to Oct 15, 1924, that I last saw him alive on Oct 15, 1924, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

Hyper. Prostate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Manninger, M. D.

Oct 15 1924 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: Oct 17 1924

20 UNDERTAKER: W. R. Cook — ADDRESS: 1003 N. Gilmor

E—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91096

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4203 Connecticut Avenue St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....John Dimling.....

(a) Residence No.....4203 Connecticut Avenue St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced - HUSBAND of (or) WIFE of Christine Dimling

6-DATE OF BIRTH (month, day and year) Mar. 27, 1860

7-AGE,	If LESS than 1 day,
64 yrs. 6 mos. 16 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)..... Owner

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, John Dimling

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Catherine Weinmiller

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Christine Dimling

(Address) 4203 Connecticut Ave.

15- Filed ..... 192 ..... Registrar.

CT 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept - 6, 1924, to Oct - 13 - 1924

that I last saw h— alive on Oct - 13 -, 1924,

and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Vascular Dis - Arteria - Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene - Foot - Jan. 6 -

Embolic — (Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? not Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Harold Brenler, M. D.

10-14-, 1924 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 192
Glen Mount Cem	Oct. 16 24
20-UNDERTAKER.	ADDRESS
Geo. L. B. Cook	1003 W. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91097

CERTIFICATE OF DEATH.

3/ D 91097

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Brune ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Horsey

(Residence in Baltimore: No. 617 Brune St (Life) St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ~~Oct~~ ~~14th~~ ~~1924~~ (Month) (Day) (Year)

7-AGE, 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Ross

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Inkum

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roland D. Savage

(Address) 1065 Myrtle Ave.

15-

Filed....., 191.....

Robert P. Harrison,

Registrar.

OCT 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1924. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5th 1924, to Oct 14th 1924, that I saw h-r alive on Oct 14 1924, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis (Pulmonary)

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) Jas O Carson M. D.

10-15-1924 (Address) 1063 Myrtle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 10/17/24

20-UNDERTAKER Helen A Hedian ADDRESS 1631 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91098 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 29 E. Washington St. W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Operowski

(a) Residence No. 29 E. Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced. (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Dec 26-1919

7-AGE. 4 yrs. 8 mos. 19 ds. | If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) " "
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS:
10-NAME OF FATHER. Stanislaus Operowski
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland
12-MAIDEN NAME OF MOTHER. Helena Skolimska
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14-(Informant) Stanislaus Operowski
(Address) 29 E Washington St

15-Filed OCT 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 15/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 9 19 24 to Oct. 15 19 24
that I last saw h alive on Oct 15 19 24
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:

Diphtheria } Nasa-Pharyngeal Tonsillar Laryngeal
(Duration) yr. mos. 6 ds.
CONTRIBUTORY (Secondary) Paralysis of Cardiac nerv.
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? residence
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Carl J. Freyberg M. D.
10/15, 19 24 (Address) 2402 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus | DATE OF BURIAL, Oct. 16, 1924

20-UNDERTAKER: Wm Fiaschwalk | ADDRESS 168 Eastern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If any ground state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 91099 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 91099

CERTIFICATE OF DEATH. 24-001

1-PLACE OF DEATH City of BALTIMORE: (No. Hemlock Road near Old Harford Rd St., 27 Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Emil Osenburg

(Residence in Baltimore: No. 1 Hemlock Road St., yrs. 79 mos. 11 ds. 3)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, November 11 1844 (Month) (Day) (Year)

7-AGE, 79 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Dyer Master
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Navy Yard

9-BIRTHPLACE, (State or Country). Hamburg - Germany

PARENTS.

10-NAME OF FATHER. X Not Known

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, X Not Known

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie Osenburg (wife)

(Address) 1 Hemlock Rd.

15- Robert P. Harrison,

Filed 5 1924 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 (Month) (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. T. Calver M. D. (Coroner.)

Oct 14 1924 (Address) 508 E. Fayette

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cemetery	Oct 16th 1924
20-UNDERTAKER,	ADDRESS
Stewart & Moreu Co.	108 W. North Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 91100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp St. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas Edward Walker

(a) RESIDENCE NO. 507 Parrish St WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 43; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant (Address): [illegible]

15 Filed OCT 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 14, 1924, that I last saw him alive on Oct 14, 1924, and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy 4

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes. What test confirmed diagnosis? Autopsy findings

(Signed) A C Manning, M. D.

Oct 17 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible]

DATE OF BURIAL: 16 1924

UNDERTAKER: [illegible]

ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Sapperstein)

D 91101 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91101.

90

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 S. Spiith ST., 5 WARD)

2-FULL NAME Harris Sapperstein

(a) RESIDENCE NO. 115 S. Spiith ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 65 — Months — Days — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Morris Sapperstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address) Jack Lewis 1439 Eutaw St

15 OCT 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 15, 1924, that I last saw him alive on Oct 15, 1924, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. D. Baughman, M. D.

10/16/19 (Address) 210 S. Spiith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Sanctuary — DATE OF BURIAL: 10/16 1924

20 UNDERTAKER: Jack Lewis 1439 Eutaw St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

D 91102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 91102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 E. Eager ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M. Roth

(a) RESIDENCE NO. 1618 E Eager ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? 5yrs. . mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of George M. Roth.

6 DATE OF BIRTH (month, day, and year) Apr. 3rd 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Heuskamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Holman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Geo. M. Roth. (Address) 1618 E Eager St.

15 Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14th 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 29, 1924. to Oct 14, 1924.

that I last saw h[illegible] alive on Oct 14, 1924.

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma 3 wks

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis

(Signed) H. C. Reuter M. D.

Oct 15, 1924 (Address) 1301 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 17 1924
20 UNDERTAKER	**ADDRESS**
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. PHYSICIANS should state EXACTLY. Every question should be carefully answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91103

CERTIFICATE OF DEATH.

74-201

D 91103

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Gibson

(a) RESIDENCE No. 923 Valley St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Gibson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

070

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Hugh Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Catherine Hagerty 1038 Homewood Ave

15 Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) undetermined (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pollitt, M. D. (Coroner.)

Oct 16/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 18 1924
20 UNDERTAKER	ADDRESS
Henry Storck Son	1501 E Eager St

BEFORE SIGNING BE CAREFUL TO SEE THAT ALL ITEMS ARE CORRECTLY SUPPLIED. Any false statement may be punished as perjury. PHRASING should be such that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 91104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91104

CERTIFICATE OF DEATH.

1574-001

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 2311 W. North Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Erb

(Residence in Baltimore: No. Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April 1 (Month) (Day), 1847 (Year)

7-AGE, 77 yrs. 6 mos. 13 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Duce

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon L. Erb

(Address) 2511 W. North Ave.

15-

OCT 16 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Oct. 16, 1924 (Address) 7 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, Oct. 17, 1924

20-UNDERTAKER Josiah Syfer

ADDRESS 1600 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Wm. Phleger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91105

CERTIFICATE OF DEATH.

D 91105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Washington Blvd. ST., 21 WARD)

2-FULL NAME William Phleger

(a) RESIDENCE NO. 819 Washington Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Phleger

6 DATE OF BIRTH (month, day, and year) May 13, 1850

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Catherine Richardson

(Address) 819 Washington Blvd.

15 Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1924

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to Oct 7, 1924, that I last saw h.. alive on Oct 7, 1924, and that death occurred, on the date stated above, at 10. P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edward Nevelaker, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park

DATE OF BURIAL Oct 17 19

20 UNDERTAKER Wm. Cook

ADDRESS 502 E North

Information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91106

CERTIFICATE OF DEATH.

D 91106

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

~~CITY OF~~ BALTIMORE: (No. Buckfield Ave (Irvington) ST., 20 WARD)

2-FULL NAME William Baker Jr

(a) RESIDENCE NO. Buckfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Parthenia Parsons

6 DATE OF BIRTH (month, day, and year) April 3rd 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Retired Glass Mfg

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 186

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas J. Baker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Bozeman

13 BIRTHPLACE OF MOTHER (city or town) Carlisle
(State or country) Pa

14 Informant Edward P Baker

(Address) 1726 Park Ave Baltimore

Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from August 28th, 1922, to Oct 14th, 1924, that I last saw h alive on Oct 14th, 1924, and that death occurred, on the date stated above, at 1135 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus, Arteriosclerosis

(duration) 16 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy and General Exhaustion (duration) 2 yrs. 7 mos. 15 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sym. & course

(Signed) J Chas Macgill, M. D.

, 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Oct 17 1924

20 UNDERTAKER J W Jenkins & Son — ADDRESS Orchard & Calhoun Sts

N. B.—WRITE PLAINLY, WITH CROSS-BOOK INK. AGE should be stated EXACTLY. PHYSICIANS should make mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91107

CERTIFICATE OF DEATH.

D 91107

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Lexington & Vincent Sts. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Leonora Schaefer Collins

(Residence in Baltimore: No. 1608 W. Lexington Street St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. January 20" 1924
(Month) (Day) (Year)

7-AGE. 4 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Alfred C. Collins

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore County Maryland.

12-MAIDEN NAME OF MOTHER. Rose E. Norris

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. C. Collins
(Address) 1608 W. Lexington Street

15-
OCT 16 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 15th 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Skull

(Duration) at once yrs. mos. ds.

CONTRIBUTORY (Secondary) Run over by Truck owned by Clover Ice Cream Co

(Duration) 19 E. Pratt St. yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

10-15 1924 (Address) Cedar & Curtis Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Oct 16" 1924

20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1103 N. Bal. St.

N. B.—Every item of information should be carefully supplied. ASK if doubtful. Do not guess. Write plainly so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91108

CERTIFICATE OF DEATH.

D 91108

1-PLACE OF DEATH St Josephs Hospital 13 155

Registered No.....

City of BALTIMORE: (No. Baltimore St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Steinfelt

(a) Residence No. 3641 Elm Ave St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Nov 2 1921

7-AGE 2 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME of FATHER Harry L Stinefelt

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER Bessie Griffith

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Harry Stinefelt

(Address) 3641 Elm Ave

OCT 16 1924

ROBERT F. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 9th 19 24 to Oct 15 19 24

that I last saw him alive on Oct 15 19 24

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(Duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Septicemia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept 26/24

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) N B Sylvest M. D.

, 19 (Address) St. Jos. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cem DATE OF BURIAL, Oct 18, 1924

20-UNDERTAKER Chenowith & Son ADDRESS 3611 Chestnut Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D 91109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Bernard ST. 17 WARD)

2-FULL NAME George H Hiness

(a) RESIDENCE No. 2811 Bernard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Hiness

6 DATE OF BIRTH (month, day, and year) July 27 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) Operator 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie E Hiness

(Address) 2811 Bernard St

15 Filed OCT 16 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1924, to Oct 14, 1924.

that I last saw h— alive on Oct 14, 1924.

and that death occurred, on the date stated above, at 7.55 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart-Disease

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Senile Dedigulment

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) R. B. Woodward M. D.

10.14.1924 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Oct 17 1924

20 UNDERTAKER CHENOWETH & SON, — ADDRESS 3617 CHESTNUT AVE.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91110 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91110

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1702 Ellamont St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albert B. Elsore

(a) Residence No. 1702 Ellamont St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	white	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6-DATE OF BIRTH (month, day and year) July 29-1850

7-AGE, 74 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer.....

9-BIRTHPLACE (city or town) Frederick Co (State or Country). Md

PARENTS.

10-NAME OF FATHER, Elijah Elsore

11-BIRTHPLACE OF FATHER (city or town) Frederick Co (State or Country). Md

12-MAIDEN NAME OF MOTHER, Susan Biggs

13-BIRTHPLACE OF MOTHER (city or town) Frederick Co (State or Country). Md

14- (Informant) Mervin E. Elsore

(Address) 3109 Walbrook ave

15- Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 24th, 1924, to Oct. 15th, 1924, that I last saw him alive on Oct. 14th, 1924, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy,

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac C. Dickson, M. D.

Oct 15, 1924 (Address) 3055 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge — DATE OF BURIAL, Oct 17, 1924

20-UNDERTAKER, Geo Weber & Son — ADDRESS 2503 Edmondson ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 167

D 91111

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 315 E. Lafayette Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Algeria V. Powder

(a) Residence No. 315 E. Lafayette Ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Hinds Powder

6-DATE OF BIRTH (month, day and year) July 11, 1845

7-AGE, 79 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or par'icular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel Foose

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Sarah N. Burton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Richmond Virginia

14- (Informant) Beryle D. Treadway

(Address) 315 E. Lafayette Avenue

15-

Filed OCT 16 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5 19.24, to Oct. 13 19.24, that I last saw her alive on Oct. 13, 19.24, and that death occurred, on the date stated above, at 9:20 p. m.

The CAUSE OF DEATH* was as follows:

Dementia Senilis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Senumentia

(Duration) 7 days yrs. mos. ds.

18-Where was disease contracted if not at place of death? NO

Did an operation precede death? NO Date of XXXXX

Was there an autopsy? NO

What test confirmed diagnosis? Symptoms Dementia

(Signed) Francis D. McCarrar, M. D.

, 19 (Address) 416 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL, 10/16 19..24

20-UNDERTAKER. Henry U. Mears & Son — ADDRESS 805 N. Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS illegible state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Rose Fullerton

D 91112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B01 1074-B 91112

1-PLACE OF DEATH

City of BALTIMORE: (No. Rose Fullerton St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Lillie Sisters of the Poor,

(a) Residence No. Preston & Valley Sts St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 15 March 1847

7-AGE, 77 yrs. 7 mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York City N.Y.

PARENTS.

10-NAME OF FATHER, James Fullerton

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant) Sister Florence

(Address) Preston & Valley

15-

Filed OCT 16 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 15 24

17- I HEREBY CERTIFY, That I attended deceased from No record, 19..., to..., 19...,

that I last saw h.. alive on Oct 12, 1924,

and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Oct 15, 1924 (Signed) H. Warner, M. D. (Address) 133 Valley N

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL, Oct. 17, 1924

20-UNDERTAKER, M. C. Means & Son ADDRESS 1535 N. Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 91113

CERTIFICATE OF DEATH.

D 91113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 W. Baelo ST., 4 WARD)

2-FULL NAME Margaret Miller

(a) RESIDENCE NO. 729 W Baelo ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baelo md
(State or country)

PARENTS

10 NAME OF FATHER Albert Miller

11 BIRTHPLACE OF FATHER (city or town) Baelo Md
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Crosley

13 BIRTHPLACE OF MOTHER (city or town) Baelo Md
(State or country)

14 Informant Albert Miller
(Address) 729 W. Baelo St

Filed OCT 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924 to Oct 14, 1924.

that I last saw h[illegible] alive on Oct 14, 1924,

and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

.....(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY
(Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Henry Glassman, M. D.

Oct 15 1924 (Address) 2607 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 10-16 1924

20 UNDERTAKER H. Brauninger & Son

ADDRESS 5[illegible] Edmondson St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91114

CERTIFICATE OF DEATH.

D 91114

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert A. Blakeney

(a) RESIDENCE NO. Elmwood Ave & Old Frederick Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 28-1850

7 AGE: Years 74 | Months — | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cotton Burnisher

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 22 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John H. Blakeney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn.

12 MAIDEN NAME OF MOTHER: Sarah Gaunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Edward H. Blakeney, Elmwood Ave & Old Frederick Rd.

Filed OCT 16 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18- 1924

17

I HEREBY CERTIFY, That I attended deceased from 9-9- , 1924, to 10-18- , 1924,

that I last saw him alive on 10-18- , 1924,

and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis peritonei

Enteric Sclerosis.

Asthma 3 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. J. Pass, M. D.

(Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Oct. 17 1924

20 UNDERTAKER: Horace A. Burgee

ADDRESS: 363 Fallo Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK CANNOT BE ACCEPTED IF TYPEWRITTEN. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91115

Registered No. D 91115

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Battle

(a) Residence No. 106 Light st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6-DATE OF BIRTH (month, day and year): 1866

7-AGE: 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: Richard Battle

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Harriett Main

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant): Hospital Records

(Address): M.T.H.

15- (Filed) OCT 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

1862

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 8 1924 to Oct. 13 1924

that I last saw him alive on Oct. 13, 1924,

and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Fractured rib; elaphantia-sis. 8 mos. Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Richard Thom M. D.

10-13-1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND DATE OF BURIAL, 19

20-UNDERTAKER: ADDRESS OCT 16 1924

Rev. Wm. R. WOODALL

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

317

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 91116

D 91116 CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 N. Gilmor ST. 16 WARD)

2-FULL NAME Baby Snowden

(a) RESIDENCE NO. 1140 Gilmor ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/14/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. & mins
	—	—	—	7 hrs 30 mins

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Walter G. Snowden

11 BIRTHPLACE OF FATHER (city or town) Baltimore County
(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise I. Snowden

13 BIRTHPLACE OF MOTHER (city or town) Carroll County
(State or country) Md.

14 Informant Mrs. Louise I. Snowden
(Address) 1140 Gilmor St.

15 Filed ..... 19..... Burial Permit Issued.
ROBERT R. KRAUTER
OCT 16 1924 1894 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14th, 1924, to Oct 15th, 1924,
that I last saw h[illegible] alive on Oct 14th 1924
and that death occurred, on the date stated above, at 2 30 A. m.
The CAUSE OF DEATH* was as follows:

Prematurity (7 Mo. Fetal)

7 hrs 30 Mins
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jas. E. Lee M. D.

. 19 (Address) 1224 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	OCT 16 1924 19..
20 UNDERTAKER	ADDRESS
Bureau of Vital Statistics	
For Wm. E. Woodall	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BAT[illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91117. ✓ D 91117.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Warner

(a) Residence No. 614 William St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Cath Warner

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER. Conrad Warner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore,

11- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

CT 1 61924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-14-24

17- I HEREBY CERTIFY, That I attended deceased from 9-4, 1924 to 10-14, 1924 that I last saw h— alive on 10-14, 1924 and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis; Myocardial degeneration

(Duration) yrs. 2 mos. (Estimated) ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lab & Autopsy

(Signed) Claude S. Drane, M. D.

10-15 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	Oct. 20, 1924
20-UNDERTAKER.	ADDRESS
F. A. Krauss, Son	703 Hanover St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91118

CERTIFICATE OF DEATH.

D 91118

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 N. Fulton Ave St., 170 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm A. Sturm

(a) Residence No. 6 N. Fulton ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliz Sturm

6-DATE OF BIRTH (month, day and year) May 25-1867

7-AGE. 57 yrs. 4 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Anthony Sturm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea Brandt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Eliz Sturm

(Address) 6 N. Fulton

15- Robert P. Harrison, 192.....

Registrar.

Burial Permit Issued

T1 67924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct-14 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct-12 1924 to Oct-14 1924

that I last saw h— alive on Oct-13 1924

and that death occurred, on the date stated above, at 140 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 1 yrs. 10 mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and

(Signed) James H. Carstairs M. D.

10/15, 1924 (Address) 1729 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	Oct. 17....., 1924
20-UNDERTAKER.	ADDRESS
J. A. Fraser & Son	703 Hanover St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91119

CERTIFICATE OF DEATH.

127 D 91119

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Isabella Fender -

(a) RESIDENCE No. 5612 Arbutus Ave - ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If ~~married, widowed, or divorced~~ HUSBAND) of ~~widow~~ (or) ~~WIFE~~ of Leon Fender

6 DATE OF BIRTH (month, day, and year) Dec 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Jersey City N J

PARENTS

10 NAME OF FATHER Wm Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: E. L. Fender

(Address) 5612 Arbutus Ave

15 OCT 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1924, to Oct. 16th, 1924, that I last saw her alive on Oct 16, 1924, and that death occurred, on the date stated above, at 10:30A m.

The CAUSE OF DEATH* was as follows:

Suppurative Cholangitis.

Chronic Cholecystitis & Cholelithiasis

Chronic Pancreatitis

(duration) Indef yrs. mos ds.

CONTRIBUTORY (Secondary) None -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes - Date of Oct. 13, 1924

Was there an autopsy? Yes - Exploratory

What test confirmed diagnosis? Autopsy -

(Signed) Keith G Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL OCT 18 1924

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may b TION is very important. See instructions on back of certificates.

Should be stated EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 91120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91120

CERTIFICATE OF DEATH.

122-6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 106-Fairoaks Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Collins

(a) RESIDENCE NO. 106-Fairoaks Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1-8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 8/27/1862

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
62	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron

(b) General nature of industry, business, or establishment in which employed (or employer) at

(c) Name of employer Town Dept.

9 BIRTHPLACE (city or town) Dalton (State or country) Md.

PARENTS

10 NAME OF FATHER James Collins

11 BIRTHPLACE OF FATHER (city or town) Dalton (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Henry Sherwood (Address) 1067 Fairoaks Ave

Filed OCT 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 14, 1924, that I last saw her alive on Oct 14, 1924; and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jos. J. Scholtes, M. D.

. 19 (Address) 4510 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 10/17 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

S.S.—WRITE PLAINLY, WITH UNFADING INK. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec– 12-23-21–E.B.R.S.—400 Blks.

D 9112F

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-08

D 9112F

1-PLACE OF DEATH

City of BALTIMORE: (No. 1009 E. Eager St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Ferrante

(a) Residence No. 1009 E. Eager St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~4/23-1922~~

6-DATE OF BIRTH (month, day and year) 4/23.1923.

7-AGE. 1 yrs. 5 mns. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Attilio Ferrante

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Concetta Giralico

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Italy

11- (Informant) Attilio Ferrante

(Address) 1009 E. Eager St.

15- Filed ..... Robert P. Harrison, Registrar.

CT 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 15-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 19 24 to Oct 15 19 24

that I last saw h alive on Oct 15 19 24,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Bornstein M. D

10/15, 1924 (Address) 733 Lexington St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. 10 17 1924

20-UNDERTAKER. George J. Smith ADDRESS 1735 Hanford Ave

George J. Smith

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Jos. Hosp. St., 9 Ward) Registered No. 1001

2-FULL NAME William Krause

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3112 Ellerslie ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary G. Krause

6-DATE OF BIRTH (month, day and year) Dec 14 1867

7-AGE, 57 yrs. 10 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:

10-NAME OF FATHER Adam Krauer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Mary G. Krause

(Address) 3112 Ellerslie ave

15- Oct 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 16 24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1924 to Oct. 16, 1924, that I last saw him alive on Oct. 16, 1924 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic. and Clin. Exam.

(Signed) Geo B. Sybert M. D.

10/16, 1924 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Oct 20..., 1924

20-UNDERTAKER. Henry Lutz ADDRESS 1203 E. Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 6 1924

Spec.—1-10-21—M&T—1500 Bks.

D 91123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91123

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 N. Washington ST., 8 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J Hammer

(a) RESIDENCE No. 1510 N. Washington ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte J Hammer

6 DATE OF BIRTH (month, day, and year) Sept 2 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Charlotte J Hammer
(Address) 1510 N Washington

15 Filed OCT 16 1924 19.....

Robert P Garrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15 19 24

17 I HEREBY CERTIFY, That I attended deceased from 6-1 ..... 19 24 to 10-15 ..... 19 24 .

that I last saw h[illegible] alive on 10-14 ..... 19 24 .

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cor Dis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. J Hammer, M. D.

....., 19 (Address) 1510 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 17 19 24

20 UNDERTAKER Henry Lutz ADDRESS 1203 N Broadway

B.—WRITE PLAINLY, WITH UNFADING INK. THIS PARAGRAPH AND PARAGRAPH NUMBERS MUST NOT BE ERASED. Every question on this certificate should be carefully answered. If unknown, so state. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91124

175-2/3

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 D 91124

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ? ST., ? WARD)

2-FULL NAME Jane M. Rhodacker

(a) RESIDENCE NO. Fort Dupont Del ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sergt L. T. Rhodacker

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	54	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ira Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 17 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 15, 1924, that I last saw her alive on Oct 15, 1924, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Fort Dupont Delaware

Did an operation precede death? Yes Date of 10/7/24

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James Arthur Wearburg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington DC — DATE OF BURIAL: Oct 17 1924

20 UNDERTAKER: Joseph Ahearn — ADDRESS: 22 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. AGE should be stated EXACTLY. mation should be carefully supplied.

Cor.—1-12-23—M&T—100 Bks.

D 91125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

D 91125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 N. Mount ST., 19 WARD)

2-FULL NAME Charles W. Augustus

(a) RESIDENCE No. 301 N. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Augustus

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abraham Augustus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Augustus

(Address) 301 N. Mount St.

15 Filed OCT 17 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. 1st day mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.

(Coroner.)

Oct 16th 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL Oct 17 1924

20 UNDERTAKER Frederick L. Dudley ADDRESS 1118 N. Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91126

101-001

D 91126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Orchard ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Jones

(a) RESIDENCE. NO. 531 Orchard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jones

6 DATE OF BIRTH (month, day, and year) Nov 10 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook - private family

(b) General nature of industry, business, or establishment in which employed (or employer) Private home

(c) Name of employer Mrs Sloan

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Lewis Jones

(Address) 531 Orchard St.

15 Filed OCT 17 1924 19 ROBERT H. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to Oct 14, 1924, that I last saw h alive on Oct 14, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Fibro sarcoma breast

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Phys. exam.

(Signed) Thos. J Keller, M. D.

, 19 (Address) 2 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct. 17 1924
20 UNDERTAKER Wm J. G. Locke	ADDRESS 1302 Jeffer

N. B.—WHITE PAPER. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of cer of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91127

1-PLACE OF DEATH

City of BALTIMORE: (No. 827 Poplar Grove St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Andrew Hild

(a) Residence No. 827 Poplar Grove St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Hild

6-DATE OF BIRTH (month, day and year) Aug. 18, 1845

7-AGE, 79 yrs. 1 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Harford County (State or Country), Maryland

PARENTS.

10-NAME OF FATHER John William Hild

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER Sarah Struelhoff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Miss Lila M. Hild

(Address) 827 Poplar Grove St.

15- Filed OCT 17 1924

Burial Permit Clerk.

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1923 to Oct 16, 1924 that I last saw h[illegible] alive on Oct 16, 1924 and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Left Side Hemiplegia

Terminal

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John A. Wieland, M. D.

10-16, 1924 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Calvary Cem	Oct 18, 1924
20-UNDERTAKER	ADDRESS
Geo L.B. Cook	1003 W. Baltimore St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—5M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

178 D 91128 — 161-001 D 91128

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zimmerman

(a) RESIDENCE NO. Ft Frederick Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male — 4 COLOR OR RACE White — 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Roger Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Fravorite

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 17 1924 19 ..... Registrar
Burial Permit Clerk.
ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 - 1924

17
I HEREBY CERTIFY, That I attended deceased from Oct 16 - 1924 to Oct 16 - 1924,
that I last saw him alive on Oct 16 - 1924,
and that death occurred, on the date stated above, at 5:00 P m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Frederick, Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sign of infant

(Signed) ..... M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. — DATE OF BURIAL Oct 17 1924

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 91129

D 91129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 W. Pratt ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen. Chamber

(a) RESIDENCE NO. 429 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sd. Chamber

6 DATE OF BIRTH (month, day, and year) Nov. 15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Skala Greece

PARENTS

10 NAME OF FATHER John Mcbombakos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Charles Chamber

(Address) 429 W. Pratt st.

15 OCT 17 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 16, 1924.

that I last saw h. alive on Oct 16, 1924.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

CONTRIBUTORY (Secondary) Gangrene Scrotum (duration) yrs. 1 mos ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) B.O. Kelly, M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 17 1924

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Hayford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155

D 91130

Registered No.

1-PLACE OF DEATH: St Josephs Hospital

City of BALTIMORE: (No. ~~2429 E. Eager~~ St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Ida Mary Adelung

(a) Residence No. 2429 E Eager St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): April 24/1921

7-AGE: 3 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Sidney Adelong

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balt

12-MAIDEN NAME OF MOTHER: Ida Brewer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balt

14-Informant: Sidney Adelong

(Address) 2429 E Eager St

15-Filed OCT 17 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 18, 1924, to Oct 14, 1924

that I last saw her alive on Oct 14 1924,

and that death occurred, on the date stated above, at 12.00 P.m.

The CAUSE OF DEATH* was as follows:

Malignant endocarditis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of Lungs

Fever (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 9/24.

Was there an autopsy? No

What test confirmed diagnosis? Clin. Path. Lab. Test

(Signed) Leo Dr Sylvest M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Oct 17, 1924

20-UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hayford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9113F

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Beech Ave ST. 13 WARD)

2-FULL NAME Charles Francis O'Neill

(a) RESIDENCE. NO. 3306 Beech Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

D 9113F

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plaster
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Daniel O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McCourt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James O'Neill
(Address) 3306 Beech Ave

Filed OCT 7 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14 1924

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1924, to October 14, 1924, that I last saw him alive on October 14, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) George C. Medairy. M. D.

, 19 (Address) 3304 Gilmor Terrace

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 16 1924
20 UNDERTAKER	ADDRESS
Martin Tuskey Son	1521 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

175 D 65 91132

CERTIFICATE OF DEATH.

T 52 D 91132

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet C. Louden

(a) RESIDENCE NO. 616 E. E. St. ST., [illegible] WARD Govt Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1910

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
14	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harvey Louden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Burial Permit Registrar.

OCT 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 15, 1924, that I last saw h[illegible] alive on Oct 15, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary infarct

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Oct 18 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light st

N. B.—WRITE PLAINLY, WITH UNFADING INK. All the items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91133

CERTIFICATE OF DEATH.

1291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Lyndhurst Av ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dixon Hull

(a) RESIDENCE No. 2603 Lyndhurst Av ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of T. Burling Hull

6 DATE OF BIRTH (month, day, and year) Dec 5 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Isaac E. Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Spence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James D. Hull

(Address) 2603 Lyndhurst Ave

Filed OCT 17 1924 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 26th, 1924, to Oct. 15th. 1924, that I last saw her alive on Oct. 15th. 1924, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

Probably at least a

Month (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic, Chemical

(Signed) Eduiger C. Tyrell, M. D.

, 19 (Address) 1700 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Oct 17 1924
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91134

CERTIFICATE OF DEATH.

11-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Mosher St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Scott

(a) RESIDENCE No. 1421 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	40	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Mr. Henry Fox

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Benjamin Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Katie Samples

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Lucy Hunt 112 Boyd St.

15 OCT 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12th, 1924, to Oct 14th, 1924, that I last saw h[er] alive on Oct 14th, 1924 and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Asa E. Bell M. D.

10-15 1924 (Address) 1224 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M[t] Auburn — DATE OF BURIAL: Oct 17 1924

20 UNDERTAKER: Sam'l M. Cogsel & Son — ADDRESS: 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

D 91135 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 2716 Fairley ST., 9 WARD)

2-FULL NAME Elizabeth Marie Griffin

(a) RESIDENCE NO. 2716 Fairley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. A. Griffin

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Marie Burch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Emma Griffin
(Address) 2716 Fairley St

Filed OCT 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Probable Congenital Heart

Very plainly Convulsions

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Haven, M. D.
(Coroner.)

Oct 16, 192 4 (Address) 5 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 17 1924

20 UNDERTAKER Wendell Dippel

ADDRESS 375 Am St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91136

CERTIFICATE OF DEATH.

155 D 91136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 15 WARD)

2-FULL NAME Owen Kelly

(a) RESIDENCE No. 1555 N. Bolton Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Gilbert F. Kelly

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Hester O'Mara

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Hospital Record

(Address)

15 Filed OCT 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/24

17

I HEREBY CERTIFY, That I attended deceased from Dec. 13 1923, to Oct 15 1924, that I last saw him alive on Oct 23 1923, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of both Femurs, Tibiae, Fibulae.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. W. Kelley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 10-18-1924

20 UNDERTAKER H. C. Braumgard

ADDRESS 527 N. Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91137 HEALTH DEPARTMENT—CITY OF BALTIMORE

43

CERTIFICATE OF DEATH.

D 91137

REGISTERED No. D 91137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 W 30th ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno. F. O'Brien

(Residence in Baltimore: No. 346 W 30th St.; 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 17 (Day), 1856 (Year)

7-AGE, 68 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 416
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jno. O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Brasil

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. R. Slawbaugh

(Address) 346 W 30th St

15- OCT 17 1924 Registrar. Burial Permit Clerk. HAROLD R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 15 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1924, to Oct 15 1924, that I saw h[im] alive on Oct 12 1924, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Concussion of Lungs

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. McVeagh M. D.

Oct 17, 1924. (Address) 3543 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, OCT 18, 1924

20-UNDERTAKER H. C. Brauning & Son — ADDRESS 5111 Belmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91138

CERTIFICATE OF DEATH.

D 91138

1-PLACE OF DEATH

City of BALTIMORE: (No. 706 East Randall St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances M. Minister

(a) Residence No. 106 E. Randall St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 20 1913

7-AGE. 11 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. Wm A Minster

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Viola Rush

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) William A. Minster

(Address) 106 E. Randall

15- Filed OCT 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1924 to Oct 16 1924

that I last saw h[illegible] alive on Oct 16 1924

and that death occurred, on the date stated above, at 745 P m.

The CAUSE OF DEATH* was as follows: Malignant Diphtheria

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Infected Tonsils

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? At School

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Hist.

(Signed) H Kentmann M. D

, 19 (Address) 1340 N Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill — DATE OF BURIAL, Oct 17, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1590 D 91139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Helen Schlosser

(a) RESIDENCE NO. 117 E. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

1601 D 91139

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Schlosser

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Thompson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed OCT 17 1924 ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2- 1924, to Oct 10 1924,

that I last saw he alive on Oct 10 1924,

and that death occurred, on the date stated above, at 4 40 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY
(Secondary) .....
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund A. Kemper, M. D.

10/17, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

318.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 91140

Registered No.

1-PLACE OF DEATH

D 91140

City of BALTIMORE: (No. 808 Mount St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Grant

(a) Residence No. 808 Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced. (Write Word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 15, 1924

7-AGE. 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 2 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Alexander Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Helen Grant

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14-

(Informant)

(Address)

15- OCT 17 1924 H. KRAUCH, Registrar.

Burial Permit Clerk

1866

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1924 to 19..., that I last saw h. alive on Oct 15 19 24, and that death occurred, on the date stated above, at 9:30 P. M. The CAUSE OF DEATH* was as follows:

Weakness

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Burns M. D

10-15-1924 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. ..., 19...

20-UNDERTAKER.

ADDRESS

Commissioner of Health

OCT 17 1924

318

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 111-00

D 91141

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hospital ST., (WARD)

2-FULL NAME Jacob Ruth

(a) RESIDENCE No. Unknown ST., WARD Catonsville Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Aug 2 - 1882

7 AGE — Years 42 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Dore

(Address) 1529 Mount St.

OCT 17 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10—14— 1924

17 I HEREBY CERTIFY, That I attended deceased from 10—6 . 1924 . to 10—14 . 1924 .

that I last saw h— alive on 10 — 14 — . 1924 .

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gastrorrhagia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. W. Butler Butler M. D.

. 19 (Address) 253 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 17 1924

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 N. Carey St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002

D 91142

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 338 Gwynn Ave ST., 20 WARD)

2-FULL NAME Marguerite Mendelsohn

(a) RESIDENCE NO. 338 Gwynn Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mendelsohn

6 DATE OF BIRTH (month, day, and year) Aug 19 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Henry C. Dr Grammont

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant John Mendelsohn
(Address) 338 Gwynn Ave

Filed OCT 7 1924 192

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) at once yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Oct 16 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fulton Park Cem	Oct 17 1924
20 UNDERTAKER	ADDRESS
W M Renton	2238 N Avenue

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91143
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

24 90

Registered No. D 91143

City of BALTIMORE: (No 102 E Hamburg St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Wm. Raidy

(Residence in Baltimore: No. 102 E Hamburg St.; yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: July 15 (Month) (Day) 188[illegible] (Year)

7-AGE: 38 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bartender
(b) General nature of Industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John Raidy

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Sophia Henkel

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Martha Raidy

(Address) 102 E Hamburg St

OCT 17 1924 (Filed) 192[illegible]

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16th 192[illegible]
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said decessed came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] Raidy M. D.
(Coroner.)

Oct 16 192[illegible] (Address) 1639 Broadway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: 10-20 192[illegible]

20-UNDERTAKER: E & J Hook — ADDRESS 115 E Mad[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

U.S.A.

Spec.—1-10-21—M&T—1500 Bks.

D 91144 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91144

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Broadway & Green ST. 2nd Prec. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Radcliffe

(a) RESIDENCE NO. 2806 Overland ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Elsie Radcliffe

6 DATE OF BIRTH (month, day, and year) Aug 20, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Credit Manager

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Phillips Bros.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harrison Radcliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newark, Del.

12 MAIDEN NAME OF MOTHER Minnie Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Elsie Radcliffe

(Address) 2806 Overland Ave

15 OCT 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1924, to Oct 17 1924, that I last saw him alive on Oct 17 1924, and that death occurred, on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis - followed by paralytic illeus and peritonitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Toxemia & Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/16/24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) I. B. Whaley, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 20 1924

20 UNDERTAKER Edw. Lovett — ADDRESS 5 N E Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OAK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174-001

D 91145

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Remat St., 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace M. O'Connell

(a) Residence No. Mount Hope Remat St., 28 Ward Birmingham Ala

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? 50 yrs. 1 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Mr O'Connell

6-DATE OF BIRTH (month, day and year) Aug 31- 1874

7-AGE, 50 yrs. [illegible] mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Meodesha Kans.

PARENTS.

10-NAME OF FATHER, Theo. Johnston

11-BIRTHPLACE OF FATHER (city or town) (State or Country), (?) Colorado

12-MAIDEN NAME OF MOTHER, Ruth (?)

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known Not Known

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Baltimore Md

15- Filed APR 7 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1924, to Oct 15 1924, that I last saw h.e alive on Oct 15 1924, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis - Total Cerebral Hemorrhage

abt (Duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Paralytic Dementia

abt (Duration) 4 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Birmingham Ala.

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Meodesha Kansas. DATE OF BURIAL, Oct 17th 1924

20-UNDERTAKER STEWART & BROWN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91146

CERTIFICATE OF DEATH. 117

D 91146

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 529 Maryland Ave ST., 25 WARD)

2-FULL NAME Myrtle F. Bayley

(a) RESIDENCE NO. 529 Maryland Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, with ordinary pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Oscar Bayley

6 DATE OF BIRTH (month, day, and year) April 12, 1903

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER James C. Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Gertrude Engerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant (Address) Mrs Harry (mother) 529 Maryland Ave.

15 Filed OCT 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1924, to Oct 15, 1924

that I last saw h[illegible] alive on Oct 15, 1924

and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 14/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell, M. D.

17, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarhill — DATE OF BURIAL Oct 18 1924

20 UNDERTAKER Morgate & E. Flynn — ADDRESS 1417 Light St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91147

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 91147

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 152 Dolphin St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Nathaniel Lemmon

(a) Residence No... 152 Dolphin St.,.....Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Color

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Lemmon

6-DATE OF BIRTH (month, day and year) 1858

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hod-Carrier

(b) General nature of Industry, business, or establishment in which employed (or employer) Carrying Hod

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sarah Lemmon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emmi Mahler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Rosa Leyphart

(Address) 152 Dolphin St

OCT 17 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 15: 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Oct 15 1924 that I last saw h.. alive on Oct 15 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH was as follows:

Bright Disease

Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Garland Schmuff M. D.

Oct 17, 1924 (Address) 1534 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	Oct 19, 1924
20-UNDERTAKER.	ADDRESS
J. Wesley Elliott	1120 Eastland Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91148

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 S. Eastan Av Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Fassell

(a) Residence No. 419 S. Eastan Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. 4-COLOR OR RACE, W. 5-Single, Married, Widowed, or Divorced (Write the word.) W.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Fassell

6-DATE OF BIRTH (month, day and year) Dec. 8-1836

7-AGE. 87 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) City

PARENTS.
10-NAME OF FATHER, John Fassell
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto
12-MAIDEN NAME OF MOTHER, Dorthman
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Annie Fassell
(Address) 419 S Eastan.

15- Robert P. Harrison,
Filed ..... 192 ..... Registrar.

OCT 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 14th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1924 to Oct 14 1924
that I last saw h.er alive on Oct 13 1924
and that death occurred, on the date stated above, at 1030 P.M.
The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Arthur Webb M. D
. 19 (Address) 330 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Oct 18. 1924

20-UNDERTAKER. J. G. Moran ADDRESS 300 E. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91149

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Joseph Cole

(a) RESIDENCE NO. 5909 Clarke Hill Rd Washington ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7le yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mrs Joseph Cole

6 DATE OF BIRTH (month, day, and year) Jan 29, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	70	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country)

PARENTS

10 NAME OF FATHER Joseph Cole

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Rosa Kelley

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mamie G. Cole

(Address) 5909 Clarke Hill

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CT 1 71924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1924, to Oct 16, 1924.

that I last saw him alive on Oct 16, 1924,

and that death occurred, on the date stated above, at 5.55 Pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of the head of the Pancreas

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Peritonitis following rupture of Duodenal Ulcer (duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? At home Mt Washington, Md.

Did an operation precede death? yes Date of Sept 29, 1924

Was there an autopsy? yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Raymond L Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park | DATE OF BURIAL Oct 18 1924

20 UNDERTAKER John O. Mitchell | ADDRESS 120 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE INFORMATION ... AGE should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91150 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91150

CERTIFICATE OF DEATH. 57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 15 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Auer

(a) RESIDENCE NO. 2817 Eutaw Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jul 29 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: E. Lupez

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records

15 OCT 17 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 15, 1924, that I last saw h alive on Oct 15, 1924, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Staphylococcic Septicaemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & bl. Culture

(Signed) Trevor Owen, M. D.

Oct 16 1924 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 18, 1924
20 UNDERTAKER John O. Mitchell	ADDRESS 1200 W Fayette

528.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be EXACTLY. mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9115E

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9115E

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1918 N Laurale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Wild

(a) Residence No. 1918 N. Laurale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Wild

6-DATE OF BIRTH (month, day and year) Jan 6-1851

7-AGE, 73 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Henry Schneider

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dora Leuw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Christian Wild

(Address) 2097 N Belair road

15- Filed OCT 17 1924, 192.. Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 15/1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2, 19 24, to Oct. 15, 19 24,

that I last saw her alive on Oct 15, 19 24,

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia of lungs

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Cath.

(Signed) Howard A Kelly M. D.

10 Oct 19 24 (Address) 7357 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL, Oct 18, 1924

20-UNDERTAKER, John Ellis & — ADDRESS 2008 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91152 ✓ D 91152

CERTIFICATE OF DEATH.

375-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 So. Highy St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rose Culotth (Culotta)

(a) Residence No. 212 So. Highy St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 3/19/1914

7-AGE. 10 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Antonio Culotta

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Mary Elarda

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-

(Informant) Antonia Culotta

(Address) 212 S. High St

15-

Filed OCT 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 17-24

17- I HEREBY CERTIFY, That I attended deceased from October 6 – 1924 to October 17 1924

that I last saw her alive on October 16 1924

and that death occurred, on the date stated above, at 2.35 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis & Convulsions

(Duration) yrs. 3 mos. 17 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D G W Kennard M. D

10-17 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Oct 20 1924
20-UNDERTAKER. John Ulrich	ADDRESS 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91153

CERTIFICATE OF DEATH.

90 D 91153

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 666 W Fayette ST., 4 WARD)

2-FULL NAME Emma R. Clark

(a) RESIDENCE NO. 666 W Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H

6 DATE OF BIRTH (month, day, and year) Aug 31 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	76	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Wm Brison

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Carlyon

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant ..... (Address) 666 W Fayette

15 Filed Oct 17 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CT 1 71924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1924, to Oct 15, 1924, that I last saw h[illegible] alive on Oct 16, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Chronic Valvular Heart Disease

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

Oct. 19 1924 (Address) 1268 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Oct 15	1924 19
20 UNDERTAKER	ADDRESS
Fun Coch	502 E Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be made. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91154 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hold Caswell St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James G. Turner

(a) RESIDENCE No. Hanover, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1864

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
5-8	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Life Insurance Agt.
(b) General nature of industry, business, or establishment in which employed (or employer) 011
(c) Name of employer

9 BIRTHPLACE (city or town) Not Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Jos. A. Staley
(Address) Fulton & Fayette St

15 [illegible] 192 Robert P. Garrison. Registrar
Burial Permit Clerk.

OCT 17 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. disease heart

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema

Duration yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Oct. 17, 1924 (Address) 165 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hancock Md	10/18 1924
20 UNDERTAKER Jos. A. Staley Fulton &	ADDRESS Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91155

CERTIFICATE OF DEATH.

D 91155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2953 Bernard ST., 17 WARD)

REGISTERED NO. 159-007

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred G. Boston

(a) RESIDENCE NO. 2953 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25-1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
—	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Francis A. Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER May R. Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Francis A. Boston (Address) 2953 Bernard Av.

15 OCT 17 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1924

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to Oct 17, 1924.

that I last saw h.. alive on Oct 14, 1924,

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Goldsborough, M. D.

, 19 (Address) 2923 - St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Oct. 18 1924
UNDERTAKER Horace H. Burgee	ADDRESS 363 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--1-10-21—M&T—1500 Bks.

D 91156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91156

CERTIFICATE OF DEATH.

127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank De Melia

(a) RESIDENCE NO. 114 No. Pine Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary De Melia

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

PARENTS

10 NAME OF FATHER Angelo De Melia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Menechino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant New York & Brooklyn Casket Co. (Address) 703 Bedford Ave—Brooklyn N.Y.

15 , 19 Robert P. Harrison, Registrar

OCT 17 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17 1924

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to Oct 17, 1924, that I last saw him alive on Oct 17, 1924, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Amoebic Abscess of liver with extension to right lung.

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct 20-1924

Was there an autopsy? No Surgical Pathology Laboratory

What test confirmed diagnosis?

(Signed) Jas. J. Mason, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn New York — DATE OF BURIAL Oct 20 1924

20 UNDERTAKER Stewart & Moore Company — ADDRESS 108 W. North Ave.

N.B.—WRITE PLAINLY, WITH INK OR TYPEWRITER. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91157

CERTIFICATE OF DEATH.

D 91157

74-801

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1827 N. Montford Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Diehl

(a) Residence No. 1827 N. Montford Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 2Nd 1850

7-AGE. 74 yrs. 6 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Pa.

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14-

(Informant) Mrs. Jennie Leicht

(Address) 1827 N. Montford Ave.

15-

Filed Robert P. Harrison Registrar.

CT 181324

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 17-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1923 to Oct. 17 1924

that I last saw h alive on Oct. 12 1924

and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Plyer Brumbach M. D.

10-17 1924 (Address) 1531 E. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Fissels Pa.

DATE OF BURIAL, Oct 19t 1924

20-UNDERTAKER: E. LeRoy Stiffler

ADDRESS 125 E. North Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91158

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1102 E. Fort Ave. (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda (Baker)

(a) RESIDENCE NO. 1102 E Fort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: W

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura C. Stout

6 DATE OF BIRTH (month, day, and year): — — 1851

7 AGE: Years 73; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fred Co Md.

PARENTS

10 NAME OF FATHER: Hilt Baker

11 BIRTHPLACE OF FATHER (City or town) (State or country): Fred Co Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Fred Co Md.

14 Informant: Wm Baker

(Address) 1102 E Fort Ave

15 [illegible] 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924 to Oct 16, 1924, that I last saw him alive on Oct 16, 1924, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Senile Impaired health

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Williams, M. D.

10/17 1924 (Address) 1 E. Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk.

DATE OF BURIAL: 19 24

20 UNDERTAKER: J. F. Baker Sons

ADDRESS: 13 E Lafayette

OCT 18 1924

GEO.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91159

D 91159

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 Elwood Place ST., 8 WARD)

2-FULL NAME Barbara E. Bahn

(a) RESIDENCE NO. 1911 Elwood Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 25 1870

7 AGE: 54 (Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Pa

PARENTS

10 NAME OF FATHER: Samuel F. Bahn

11 BIRTHPLACE OF FATHER (City or town) (State or country): York Pa

12 MAIDEN NAME OF MOTHER: Barbara Wagner

13 BIRTHPLACE OF MOTHER (City or town) (State or country): York Pa.

14 Informant: Amanda Heise
(Address) 1911 Elwood Place

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

1 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I attended deceased from December, 1923, to Oct. 16th, 1924, that I last saw her alive on Oct. 13th, 1924 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH,* was as follows:

Gastric Cancer,

(duration) 1 yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary): None apparent,

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? Yes Date of Jan. 1/24,

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) C. H. Hoffheimer, M. D.

10/17 1924 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Penn'a

DATE OF BURIAL: Oct 18 1924

20 UNDERTAKER: Robt J Sumwalt Jr

ADDRESS 1742 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91160

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 S Stockton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emmaline Plaster

(a) Residence No. 14 S Stockton St.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col'd

5-Single, Married, Widowed, or Divorced, (Write the word.) Widd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 1872

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Daniel Foster

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lear Bowley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Lee Ross

(Address) 14 Stockton St

15- Filed OCT 18 1924 by Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Oct 16, 1924, that I last saw h— alive on Oct 16, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Norwood M. D.

Oct 17, 1924 (Address) 929 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn — DATE OF BURIAL, Oct 20, 1924

20-UNDERTAKER. John H. Toadvine — ADDRESS 1027 Druid Hill Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9116

CERTIFICATE OF DEATH.

D 9116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 W. Maple Ave. ST. Overlea WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lyttleton Morgan Ferguson

(a) RESIDENCE No. 113 W. Maple ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Maud Hoover Ferguson

6 DATE OF BIRTH (month, day, and year) March 24th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland.

10 NAME OF FATHER William Martin Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

MAIDEN NAME OF MOTHER Matilda Coggins

BIRTHPLACE OF MOTHER (city or town) or country) Balto. Maryland

Maud H. Ferguson
1½ W Maple ave

..., 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Oct 17, 1924, that I last saw him alive on Oct 17, 1924, and that death occurred, on the date stated above, at 8 35/A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) Edward H Benard, M. D.

(Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cemetery	Oct. 19, 1924.
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Son	Fullerton, Md.

AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of DECEASED'S terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91162

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 Patapsco Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Sophronia Campbell

(a) RESIDENCE NO. 157 Patapsco Ave ST., WARD 27
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Col

5 Single, ~~Married, Widowed~~, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Ralph Campbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Texas

12 MAIDEN NAME OF MOTHER Sophia Worthington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ralph Campbell
(Address) 157 Patapsco Ave

15 Filed OCT 18 1924, 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 19 24, to Oct 16, 19 24,

that I last saw her alive on Oct 15, 19 24

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) January

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Chas J Wells, M. D.

, 19 (Address) 2 E Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 18 1924

20 UNDERTAKER: Edward F Bewsey

ADDRESS: 1718 E Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91163 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91163

1707

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilson

(a) RESIDENCE NO. 645 Raborg St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Wilson

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records Robert P. Harrison, Health Dept.

Filed OCT 18 1924 Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16- 1924

17

I HEREBY CERTIFY, That I attended deceased from March 27. 1924. to Oct 16- 1924.

that I last saw him alive on Oct 16- 1924,

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

Empyema-

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of July 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James Wilbur Warbasse, M. D.

10-7 1924 (Address) John Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooks Chapel	Oct 19 1924
20 UNDERTAKER	ADDRESS
Edwin Stone & Son	1400 Mad

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91164 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91164

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1529 N. Wolf St St., 8 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane M. Wilson

(a) Residence No. 1529 N. Wolf St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Wilson

6-DATE OF BIRTH (month, day and year) July 11 1860

7-AGE. 64 yrs. 03 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Michael J. Nolan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Wilhelmine Schubard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Thomas E. Nolan

(Address) 1529 N. Wolf St

Filed OCT 18 1924 192 Robert F. Harrison, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 7 1924, to Oct. 16, 1924 that I last saw h. alive on Oct. 15, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. 1 mos. 9 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Ellen K. Ringgold M. D.

(Address) 1613 E. Northern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem	Oct 19 1924
20-UNDERTAKER.	**ADDRESS**
Frank A. Fink	916 N. Gay St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91165

D 91165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1515 Clifton ave ST., 13 WARD)

2-FULL NAME Margarit C. Wheeler

(a) RESIDENCE No. 1515 Clifton ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fr.	W.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Wheeler

6 DATE OF BIRTH (month, day, and year) Aug 22-1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER F. Gephardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Chas. C. Wheeler
(Address) 1515 Clifton ave

OCT 18 1924 Filed 192 Robert J. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrisser, M. D.
(Coroner.)

Oct 16, 1924 (Address) 3532 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Oct. 20 1924

20 UNDERTAKER H. C. Windefeld 914 — ADDRESS Greenmt Av

DURATION should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91166 ~~D 91166~~ D 91166

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

REGISTERED NO. 4 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Clarence Collins

(a) RESIDENCE NO. 742 W. Saratoga ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....—.....

(c) Name of employer .....—.....

9 BIRTHPLACE (city or town) ..... Maryland
(State or country)

PARENTS

10 NAME OF FATHER Clarence Collins

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Coates

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant Records
(Address)

Robert P. Harrison,
Registrar
Burial Permit Clerk.

OCT 8 1924 , 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 16, 1924,
that I last saw him alive on Oct 16, 1924,
and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 10-20 1924

20 UNDERTAKER Dan'l Easton — ADDRESS 916 Penna Ave

WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. PHYSICIAN'S information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CERTIFICATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1103 N. Stricker St., St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Cornish

(a) Residence No. 1103 N. Stricker St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred over 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of Levi Cornish

6-DATE OF BIRTH (month, day and year) Jan. 1-1848

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), —

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), —

11- (Informant) Levi Cornish,

(Address) 1103 N. Stricker St.

13- 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 17-'24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1924 to Oct 16 1924

that I last saw him alive on Oct. 16 1924

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy M. D.

, 19 (Address) 2410 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	10-20-1924
20-UNDERTAKER	ADDRESS
Dan'l Easton	916 Penna Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91168

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U.S. Marine Hosp. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hans Hansen

(a) RESIDENCE NO Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of "

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Dr. Foster
(Address) U.S. Marine Hospital

15 Filed OCT 18 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)
Oct 16, 1924 (Address) 3532 Orlando Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	10/18, 1924
20 UNDERTAKER	ADDRESS
Jos Levinson & Bro	1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91169

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 E. Preston St ST., 8 WARD)

2-FULL NAME Georgia Askew

(a) RESIDENCE No. 2414 E. Preston St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John T. Askew

6 DATE OF BIRTH (month, day, and year) August 10, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	62	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamtress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salem, N. J.

PARENTS

10 NAME OF FATHER Benjamin Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salem, N. J.

12 MAIDEN NAME OF MOTHER Mary Ellen Denn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.?

14 Informant John E. Askew (son)

(Address) 2028 E. North Ave

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk

OCT 18 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS PAPER IS SENSITIZED. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16/24 19

17

I HEREBY CERTIFY, That I attended deceased from October 1st. 1924 to October 16. 1924

that I last saw her alive on October 16/24 19

and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. H. Gallen, M. D.

10/16/24 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	10/20 1924
20 UNDERTAKER Philip Henry	ADDRESS 206 Orleans St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91170

CERTIFICATE OF DEATH.

179 D 91170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Stanley

(a) RESIDENCE No. 1220 Mc Elderry St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXXXXX

6 DATE OF BIRTH (month, day, and year): July 22/1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: school girl
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Edgar Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mable Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Della Stanley

(Address): 1220 Mc Elderry St

Filed OCT 18 1924 192 Robert F. Harrison, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis-Odema Of Brain
1st & 2nd degree burns over body & extremities. (Clothing caught fire while playing with matches

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) (Autopsy)

(duration) 2 yrs. mos. ds.

(Signed) J. S. Hoelen M. D. (Coroner.)

10/17/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10/19/24 1924
20 UNDERTAKER	ADDRESS
Byron Wright	1215 Mc Elderry

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that i
TION is very important See instructions or

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9117F

CERTIFICATE OF DEATH.

100 D 9117F

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Clarke

(a) RESIDENCE No. 1000 Argyle ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 5 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9. 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Clarke

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lola Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lola Clarke
(Address) 1000 Argyle ave

15 Filed Oct 18 1924 Registrar

CT 1 8 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W K Forsech, M. D.
(Coroner.)

Oct 16, 1924 (Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Oct. 18 1924

20 UNDERTAKER Mrs. M. Johnson — ADDRESS 1309 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Bruno Palumbo

D 91172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruno Palumbo

(a) RESIDENCE No. 7 Offut St - Cumberland Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Palumbo.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Frank Palumbo.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Jennie Pinos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Four months.

(Address)

15 Filed OCT 8 1924, 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17 1924

17

I HEREBY CERTIFY, That I attended deceased from 9/30/24, 19 , to 10/17/24 19 ,

that I last saw him alive on 10/2/24, 19 ,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculoma of Brain.

Tuberculous Meningitis

(duration) yrs. 5 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 10/16/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Winston J. M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md	Oct 18 1924
20 UNDERTAKER: William Cook	ADDRESS: 502 E Nad

B.—WRITE PLAINLY, WITH PENCIL OR INK. PHYSICIANS should be careful in filling out information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91173

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-0B 91173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1763 Abbottston St 9 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Irvin Green

(a) Residence No. 1763 Abbotts ton St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A

6-DATE OF BIRTH (month, day and year) Feb 4 1847

7-AGE. 77 yrs. 7 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wm. J. Poole & Co

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thomas Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Eng.

12-MAIDEN NAME OF MOTHER, Alice Irvin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs August Lincke

(Address) 1763 Abbottston St

15- Filed ..... 192 ..... Registrar.

OCT 18 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 17 1924

17- I HEREBY CERTIFY, That I attended deceased from July 12 1924 to Oct 17 1924

that I last saw her alive on Oct 17 1924

and that death occurred, on the date stated above, at 1075 P m.

The CAUSE OF DEATH* was as follows:

General Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis with softening (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

10/17 1924 (Address) 858 Harford Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) **whether Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 20 1924

20-UNDERTAKER: Wm Cook Sons & Co — ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91174

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Eastern Avenue ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes . Wisniewski

(a) RESIDENCE No. 2104 Eastern Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Helping Daughter

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Magdalena. Palasik Daug.

(Address) 2104 Eastern Avenue

15 Filed OCT 18 1924 Robert P. Harrison, Registrar

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1924, to October 16, 1924, that I last saw h[illegible] alive on October 16, 1924, and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Casimir Kuczowski, M. D.

, 19 (Address) 2529 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct 20 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91175 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91175

100-061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. Patterson Pk Avenue WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczyslaw. Borowski

(a) RESIDENCE No. 516 S. Patterson Pk. Ave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John. Borowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Frances. Kalinowski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr. John . Borowski
(Address) 516 S. Patterson Pk Ave.

15 Filed OCT 8 1924 19 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/12 ..... 19 24 ..... to 10/17 ..... 19 24 .....
that I last saw h 4 alive on 10/17/24 ..... 19 24
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological Exam no

(Signed) Manuel A. Riehm ..... M. D.

19 (Address) 5325 Pat Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Oct. 18 19 24

20 UNDERTAKER: John A. Weber ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-D 91176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Homestead ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ausler

(a) RESIDENCE NO. 616 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 18-24

7 AGE	Years	Months	Days	If LESS than 1 day, ~~2~~ hrs. or ~~min~~.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Egbert Claude Ausler

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Panetti

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Eugene Claude Ausler
(Address) 616 Homestead

15 Robert P. Harrison,
Registrar
Burial Permit Clerk.

OCT 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Oct 18, 1924, that I last saw her alive on Oct 18 - , 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth - 5½ month
Placenta Previa -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E Gill Hall, M. D.

Oct 18 1924 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 18 1924

20 UNDERTAKER Wm & Chas John H. Penfold & Son ADDRESS 830 W. Fayette St

28—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that the DATE OF DEATH is stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91177

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001
74 D 91177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2418 St. Paul ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Nelson

(a) RESIDENCE No. 2418 St Paul ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Molly E. Nelson

6 DATE OF BIRTH (month, day, and year) July 13, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireins Adjuster
(b) General nature of industry, business, or establishment in which employed (or employer) 106
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas T. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise McPhail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Molly E. Nelson
(Address) 2418 St Paul St

15 Filed ..... 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CT 18 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (3rd stroke)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. P. Allen, M. D.
(Coroner.)

10/18/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 20 1924
20 UNDERTAKER Wm J Pickerell Sons	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91178

CERTIFICATE OF DEATH.

D 91178

1-PLACE OF DEATH West Baltimore general Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Raynor Ave & Dukeland ST., 17 WARD)

2-FULL NAME mr John William Price

(a) RESIDENCE No. 1907 E Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	~~Married~~ Widowed

5a If married, widowed, or divorced (HUSBAND of or) WIFE of mrs J. W. price.

6 DATE OF BIRTH (month, day, and year) May 15 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

0886

9 BIRTHPLACE (city or town) (State or country) maryland.

PARENTS

10 NAME OF FATHER Caleb price

11 BIRTHPLACE OF FATHER (city or town) (State or country) maryland.

12 MAIDEN NAME OF MOTHER mary Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) maryland

14 Informant Mrs Mary A. Whittle

(Address) 2918 Clifton Ave.

15 OCT 18 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/ 1924.

17

I HEREBY CERTIFY, That I attended deceased from 10/8/ , 1924, to 10/18/ , 1924.

that I last saw him alive on 10/18/ , 1924,

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis (Gangrenous)

(duration) ~~yrs~~ ~~mos~~ 13 ds.

CONTRIBUTORY (Secondary) general peritonitis

10 (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/17/24

Was there an autopsy? no.

What test confirmed diagnosis? clinical & operation

(Signed) Jas Hurst Wilkinson, M. D.

, 19 (Address) Med Bette Sentral Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 20 1924
20 UNDERTAKER Wm J Tickner & Sons	ADDRESS North & Pa

GE should be stated EXACTLY. PHYSICIAN should state
mation should be carefully supplied. AGE should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSA-
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91179

CERTIFICATE OF DEATH.

1 + 113 D 91179

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., — WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Chapman Green

(a) RESIDENCE No. Stemmers Run Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
3 mo	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Emma Haskett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant William H Green

(Address) Stemmers Run

15 Filed OCT 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Oct 18, 1924, that I last saw him alive on Oct 18 1924, and that death occurred, on the date stated above, at 6.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhea, Prematurity, Malnutrition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Marsh M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dand Dondore — DATE OF BURIAL: Upper Falls

20 UNDERTAKER: Place of Burial — ADDRESS

Reisterstown Md Oct 19, 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91180

CERTIFICATE OF DEATH.

90 D 91180

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Cuben

(a) RESIDENCE NO. 12 Montgomery Road ST., Windsor Hills WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer —

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed OCT 1 91924 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-3, 1924, to 10-16, 1924

that I last saw him alive on 10-16, 1924

and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Hypocardiac Insufficiency

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Radial Hypertrophy

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Isidor L. Levy, M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Co	10/11 1924
20 UNDERTAKER Jack Lewis	ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91181 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 91181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No.) 1120 Carroll St., 21 Ward)

2-FULL NAME... Frederick Dressel (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No... 1120 Carroll St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male — 4-COLOR OR RACE: White — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of ~~or wife~~ Jennie Dressel

6-DATE OF BIRTH (month, day and year): Feb. 22, 1859

7-AGE: 65 yrs. ..... mos. ..... ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): Bkry
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS
10-NAME OF FATHER: Gerhard Dressel
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Margusch
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Jennie Dressel
(Address): 1120 Carroll

OCT 19 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 18, 24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22, 19.. Oct 18, 24
that I last saw him alive on Oct 17, 24
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows: Cancer of Liver.

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? ..... Date of

Was there an Autopsy? No

What test confirmed diagnosis? .....

(Signed) Jno. F. Schwenker M D

19 (Address) 1176 W Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 10—21 19 24

20-UNDERTAKER: Geo Lembach & Son — ADDRESS: 647 W Pratt St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91182 H Graves Circuit CERTIFICATE OF DEATH. 74-901 D 91182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor. Fayette & Cha St. 40 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Funk

(Residence in Baltimore: No. Cor. Forest & Chase st. St.; 5a yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Col.	Widow

6-DATE OF BIRTH, Unknown (Month) ....., 1836 (Year)

7-AGE, 88 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister

(Address) Forest & Chase

15- Filed OCT 19 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1923, to Oct 17 1924, that I saw her alive on Oct 10 1924, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

.....

Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Mary F Voegtlem M. D.

Oct 18 1924 (Address) 1028 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Oct 20, 1924

20-UNDERTAKER Mrs. R.G. Edel

ADDRESS 775 Hamden

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91183

CERTIFICATE OF DEATH.

D 91183

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 90 Beech Ave. South of Gurgun Park Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Mateer Ogelsby

(a) Residence No. Beech Ave. S. of Gurgun Park Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. H. Ogelsby

6-DATE OF BIRTH (month, day and year): Feb 16. 1864

7-AGE. 60 yrs. 8 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house duties
(b) General nature of industry, business, or establishment in which employed (or employer): 837
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Penna

PARENTS.
10-NAME OF FATHER: Wm. Mateer
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Penna
12-MAIDEN NAME OF MOTHER: Eliz. Hoffmaster
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Penna.

14-(Informant): Chas. H. Ogelsby
(Address): Beech Ave

15-Filed: OCT 19 1924 ROBERT A. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 17, 1924 to Oct. 17, 1924.
that I last saw h[illegible] alive on Oct. 17, 1924,
and that death occurred, on the date stated above, at 8.10 P. m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis + Auric Fibrosis
(Duration) ... yrs. 12 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Sumwalt, M. D.

Oct 18. 1924 (Address) 4509 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Harrisburg Pa.	Oct. 20 1924
20-UNDERTAKER.	ADDRESS
John Mitchell	122 W. Fayette St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91184

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Colonial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Mary R. Ritter Sr. WARD)

2-FULL NAME 2339 Edmondson Ave (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard L. Ritter

6 DATE OF BIRTH (month, day, and year): Nov 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md

PARENTS

10 NAME OF FATHER: Conrad Schnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christiana Muller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Leonard L. Ritter
(Address) 2339 Edmondson ave

15 OCT 19 1924 (Registrar's stamp) HUBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th 1924 to Oct 17 1924, that I last saw h(e)(er) alive on Oct 17 1924, and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Prof. C. Krall M. D.

10-17 1924 (Address) 3823 Liberty Hgts ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery Leo — DATE OF BURIAL: 10/20/24

20 UNDERTAKER: Jos Weber & Son — ADDRESS: 2503 Edmondson ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91185

CERTIFICATE OF DEATH.

74001

D 91185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. Chester ST., 1 WARD)

2-FULL NAME Albert E. Yaeger

(a) RESIDENCE NO. 403 S. Chester ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Jennie D. Yaeger

6 DATE OF BIRTH (month, day, and year) Nov 15 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Yaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Schafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jennie D. Yaeger (Address) 403 S. Chester St

15 Filed OCT 19 1924 ROBERT R. KRAUTER, Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Oct 16, 1924, that I last saw h[illegible] alive on Oct 16, 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas T Lemmon, M. D.

10/18, 1924 (Address) 718 21 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthias Cemetery	Oct. 19 1924
20 UNDERTAKER	ADDRESS
Lilly + Zeiler	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91186

1-PLACE OF DEATH Hebrew Orphan Asylum

CITY OF BALTIMORE; (No.) ST., 7 WARD)

2-FULL NAME Baby Mahoney.

(a) RESIDENCE No. 1884 Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~ yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? ~ yrs. ~ mos. ~ ds.

(If non-resident give city or town and State)

1524-002

D 91186

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) ~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Oct 17, 1924

7 AGE Years ~ Months ~ Days ~ If LESS than 1 day, 6 hrs. or 11 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Christopher Mahoney

11 BIRTHPLACE OF FATHER (city or town) New York (State or country)

12 MAIDEN NAME OF MOTHER Catherine Conn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Christian Mahoney

(Address) 1524 Caroline St

15 Filed OCT 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1924, to Oct 17, 1924, that I last saw him alive on Oct 17, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? Date of ~

Was there an autopsy? Yes

What test confirmed diagnosis? ~

(Signed) Isidor S. Jay M. D.

Oct. 19 1924 (Address) Hebrew Orphan Asylum

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL—CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL Oct 19 1924

20 UNDERTAKER Sol Simon & Bro

ADDRESS 1127 E. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

Melvin 1303 W North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91187

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. D 91187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 West North ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tynch

(a) RESIDENCE NO. 1203 West North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (of) WIFE of Michael Tynch

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 84.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John H Tynch

(Address) 1203 West North

15 Date OCT 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924, to Oct 18, 1924, that I last saw h alive on Oct 18, 1924 and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. Melvin, M. D.

19 (Address) 1303 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (after Funeral) — DATE OF BURIAL Oct 23 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

OCT 19 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAPER MUST NOT BE SOILED OR MUTILATED. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Retaliate 1038 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91188

48 D 91188

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2011 Jefferson ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B Lowe

(a) RESIDENCE NO. 2011 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura B Lowe

6 DATE OF BIRTH (month, day, and year) Dec 31, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/5

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ephriam Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lola Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura B Lowe

(Address) 503 Washington St

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Oct 18, 1924.

that I last saw h alive on Oct 14, 1924

and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

Cancer of Face

(duration) 1 yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emily L Retaliate M. D.

Oct 18 1924 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 20 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91189

CERTIFICATE OF DEATH.

D 91189

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1245 Jefferson St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Dudek

(a) Residence No. 1245 Jefferson St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 18-1924

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, 2 hrs. or .....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Dudek

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Josephine Pietrzykowski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Joseph Dudek

(Address) 1245 Jefferson

15- FILED OCT 19 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 24, 19.. to Oct 18 24, 19.. that I last saw h.. alive on Oct 18 24, 19.. and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? .....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J. Kovacs M. D.

(Address) 801 N Kenwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL, Oct 19, 1924

UNDERTAKER. Wm Lisakowski ADDRESS 1618 Eastern

N. B.—WHILE ENTIRE CERTIFICATE should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 91190

D 91190

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1245 Jefferson St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Dudek

(a) Residence No. 1245 Jefferson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 18-1924

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 2 hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Dudek

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Josefa Pulczykowska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

11- (Informant) Joseph Dudek

(Address) 1245 Jefferson

OCT 19 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 19 24 to Oct 18 19 24

that I last saw h alive on Oct 18 19 24

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H Ryan M. D.

(Address) 1549 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL, Oct 19, 1924

20-UNDERTAKER. Wm Lisowski ADDRESS 1611 Eastern

N. B.—WHOLE ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91191

CERTIFICATE OF DEATH.

40

D 91191

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 7 WARD)

2-FULL NAME George Jenkins

(a) RESIDENCE NO. 2720 Calvert ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Jenkins

6 DATE OF BIRTH (month, day, and year): December 1866

7 AGE: Years 57; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant. 045

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Augusta Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Record.

(Address) .....

15 OCT 19 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/18/24

17

I HEREBY CERTIFY, That I attended deceased from 10/3/24, 19..., to 10/18/24, 19...,

that I last saw h— alive on 10/18/24, 19...,

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Nervous Prostration

Stricture Urethra

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured Urethra —

Uraemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Drainage

Did an operation precede death? Yes Date of 10/3/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) H. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 10/21 1924

20 UNDERTAKER: Chas. H. Grandt & Son — ADDRESS: 1180 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91192

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

City of BALTIMORE: (No. 3012 N. Calvert St., 17 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... David Funsten

(a) Residence No..... 3012 N. Calvert St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Virginia Caughy

6-DATE OF BIRTH (month, day and year) Aug. 24, 1862

7-AGE. 62 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer. Travelers Life Ins. Co. 086

9-BIRTHPLACE (city or town)..... Clarke Co.
(State or Country)..... Virginia

PARENTS.

10-NAME OF FATHER. Oliver R. Funsten

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Mary Bowen

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Virginia

14- (Informant) O. H. Funsten

(Address) 1106 E. Main St. Richmond, Va

15- OCT 19 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 18-1924

17- I HEREBY CERTIFY, That I attended deceased from March 1922 to Oct 15 = 1924

that I last saw him alive on Oct 17 1924

and that death occurred, on the date stated above, at 10 40 A. m.

The CAUSE OF DEATH* was as follows:

General Sarcomatosis

(Federal removal of Melanotic mole in March 1922)

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Virginia 1922

Did an operation precede death? No Date of Dec. 1923

Was there an autopsy? No

What test confirmed diagnosis? Pathological findings

(Signed) Chas W. Edmunds M. D.

Oct 18. 1924 (Address) 132 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cemetery

DATE OF BURIAL, 10/20, 19 24

20-UNDERTAKER. Henry W. Myers & Son

ADDRESS 805 N. Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

Dr Benton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91193

CERTIFICATE OF DEATH.

49 D 91193

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 570 Belair ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Spine

(a) Residence No. 570 Belair St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) April 20 1911

7-AGE, 13 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Roco Spine

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Kasbeck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Roco Spine

(Address) 570 Belair ave

15- Filed OCT 20 1924 192.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Augt 20 1924 to Oct 19 1924

that I last saw h alive on Oct 18 1924

and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma (Brain)

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Balto City

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X ray & gland

(Signed) Edwd A Benson M. D.

Oct 19, 1924 (Address) Overlea Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Oct 23 1924
20-UNDERTAKER.	**ADDRESS**
Wendell Appelson	378 N

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91194

CERTIFICATE OF DEATH.

3 | D 91194

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 226 Albermarle St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Dipietro

(a) Residence No. 226 Albermarle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Infant Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) June 16 1923

7-AGE. 1 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Vincent Dipietro

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Anna Robine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Vincent Dipietro
(Address) 226 Albermarle

15- Filed OCT 20 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 18-24

I HEREBY CERTIFY, That I attended deceased from Sept. 26 1924 to October 18 1924 that I last saw h.. alive on October 18 1924 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Health Department

(Signed) D. P. W. Kerrigan M. D.

10-19 1924 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Vincents	Oct 19 1924
20-UNDERTAKER. Wendell Appelson	ADDRESS 378 Wmm

NOTE—ENTRIES must be made EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002

D 91195

91195

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Bond ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hancock

(a) RESIDENCE NO. 1142 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jack Hancock

6 DATE OF BIRTH (month, day, and year) Feb 3, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	70	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Cheatham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sarah Wilson

(Address) 114 N Bond St

15 Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 18, 1924, that I last saw h e alive on Oct 17, 1924, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Bernard Harris, M. D.

, 19 (Address) 38 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Oct. 21 1924

20 UNDERTAKER Christ F. Johnson — ADDRESS 46 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91196 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 91196

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal T.B. Hosp St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Rein (Theodore Rein)

(a) Residence No. 1843 Covington St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) aug 19th 1875

7-AGE. 49 yrs. 1 mos. 29 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist's helper

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt md.

PARENTS.

10-NAME OF FATHER, Lewis Rein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie Ettever

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Records (Address) Municipal Hosp.

15- Filed OCT 20 1924 ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/18/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1923 to Oct 18, 1924 that I last saw h. alive on Oct 15, 1924 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Advanced Pulmonary T.B.

Chronic nephritis

Bronchial asthma

uncertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma

Lancelan (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Municipal

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard Schon M. D.

, 19 (Address) Municipal T. B.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem DATE OF BURIAL. 10/20. 1924

20-UNDERTAKER Philip Hennig ADDRESS 2006 Orleans St

N. B.—Wr... should be carefully supplied. AGE should be stated E... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91197

CERTIFICATE OF DEATH.

90 ✓ D 91197

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 N. Montford Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Zick

(a) Residence No. 124 N. Montford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick Zick

6-DATE OF BIRTH (month, day and year) April 23, 1844

7-AGE. 80 yrs. 5 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Nicholas Leithauser

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Kramschutt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Margaret Shaney

(Address) 124 N. Montford Ave

15- OCT 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 17/24

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to Oct 17 1924

that I last saw he alive on Oct 16 1924

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) A. A. Kearr M. D.

10/18 1924 (Address) 1907 Fairmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Hill Cemetery	Oct 20, 1924
20-UNDERTAKER.	ADDRESS.
J. Sander Sons	1710 Pleasant St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Should be carefully supplied. Names should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91198

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH West Baltimore General Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Rogers ave & Hutchinson ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sophie Myers.

(a) RESIDENCE NO. 49 4th Street E Baltimore City Annex ST., 25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick M. Myers.

6 DATE OF BIRTH (month, day, and year) Dec 12th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Himerd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Doris Winbalman

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Frederick M. Myers (husband) (Address) 49 - 4th St. Baltimore (East)

15 Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/24 19

17

I HEREBY CERTIFY, That I attended deceased from 10/11, 1924, to 10/19, 1924,

that I last saw her alive on 10/19, 1924,

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus,

Fracture of right Femur.

2

Diabetes Mellitus (duration) 4 yrs.

2 Fractured Femur (duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical examination & Laboratory

(Signed) Clement R. Manbar, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct 22nd 1924

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 129 D 91199

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1205 Breitwert Avenue, St. Morrell Park Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis M. Neighoff Sr.

(a) Residence No. 1205 Breitwert Avenue, St., Morrell Park Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Neighoff

6-DATE OF BIRTH (month, day and year) Oct. 20, 1860

7-AGE.	If LESS than 1 day,
63 yrs. 11 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Roofing & tinning

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer (self)

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland.

PARENTS.

10-NAME OF FATHER, Joseph Neighoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland.

12-MAIDEN NAME OF MOTHER, Josephine Winks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs. Catherine Neighoff

(Address) 1205 Breitwert Ave.

15- Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 12, 1924 to Oct 17, 1924

that I last saw him alive on Oct 17, 1924

and that death occurred, on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

& Arteriosclerosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gertrude Fiske M. D.

10-18, 1924 (Address) 2320 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Oct 20" 1924
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Bulls St

N. B.—WHITE PENCIL, WHICH will not copy, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91200

HEALTH DEPARTMENT—CITY OF BALTIMORE

123

D 91200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 22 E. Church St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Florence Wright

(a) Residence No. 22 E Church St., 22 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem.

4-COLOR OR RACE, Col.

5-~~Single, Married, Widowed, or Divorced~~ (Write word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Wright

6-DATE OF BIRTH (month, day and year) Aug 24 - 1880

7-AGE. 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Emerald

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Horace Lake

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) William Wright

(Address) 22 E Church St

15- Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/17/24

17- I HEREBY CERTIFY, That I attended deceased from 9/24/24, 19.. to 10/17/24, 19.. that I last saw h.. alive on 10/17/24, 19.. and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Chole lithiasis

Acute (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Portal Stasis

Acute (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ruey Dorsey M. D.

10/20/24 (Address) 908 Shawan Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn DATE OF BURIAL, Oct 20 1924

20-UNDERTAKER, J. H. Brown & Son ADDRESS 1011 Monte St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91201

CERTIFICATE OF DEATH.

57 D 91201

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3044 Dillon ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert S. McKay

(a) RESIDENCE No. 3044 Dillon ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cordelia O. McKay

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George S. McKay

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Cordelia O. McKay
(Address) 3044 Dillon St.

15 OCT 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1924, to Oct 16, 1924

that I last saw the live on Oct 14, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tubular Anuria of short

6

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gradual —

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Thom — M. D.

(Address) 677 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 20 1924

20 UNDERTAKER: Wm. C. Black, — ADDRESS: 927 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 91202

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-902 D 91202

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N. Dallas ST.; 7 WARD)

2-FULL NAME Henry Glantz

(a) RESIDENCE. No. 1022½ N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thresa Glantz

6 DATE OF BIRTH (month, day, and year) Dec. 25 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot & Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Thresa Glantz

(Address) 1022 N. Dallas St

15 [illegible] 1924

OCT 20 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1 to Oct. 19 1924.

that I last saw him alive on October 1 1924.

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

Senile Bronchitis (duration) yrs. mos. ds.

(CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Walter A. Meyer M. D.

Oct 20 1924 (Address) 638 N. Carolene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 22 1924
20 UNDERTAKER John H. Valentine	ADDRESS 2226 W

Important. See instructions on back of certificates. FORM STATEMENT OF OCCUPA

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 91203

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Cazourek

(a) Residence No. Mt Hope Retreat St., 28 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 6 - 1888

7-AGE. 36 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md -

PARENTS.

10-NAME OF FATHER. Peter Cazourek

11-BIRTHPLACE OF FATHER (city or town) (State or Country). (?) Bohemia

12-MAIDEN NAME OF MOTHER. Anna Volk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). (?) Bohemia

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Retreat

15- Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 6th, 1924, to Oct 18th, 1924, that I last saw her alive on Oct 17 -, 1924, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Tubroid Phthisis -

abt (Duration) 3 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Dem. Psychosis.

abt (Duration) 4 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

Oct 19th, 1924 (Signed) Frank J Flannery, M. D. (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL. Oct 22, 1924

20-UNDERTAKER. Frank Enoch Son ADDRESS 1906 Eastlake

N. B. CAREFULLY EXAMINE CERTIFICATE. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 91204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91204
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 432 S. Smallwood St., 20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Henry W. Guister

(a) Residence No. 432 S. Smallwood St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Guister

6-DATE OF BIRTH (month, day and year) May 4-1851

7-AGE. 73 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer). O.K.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Not given

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Martin F. Guister

(Address) 4320 S. Smallwood Ave

15- Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 17-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 19 24 to Oct 17 19 24

that I last saw h. alive on Oct 17 19 24

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Henry Glassman M. D

Oct 19. 1924 (Address) 2687 Wrexham Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. Oct. 20. 1924

20-UNDERTAKER. F. A. Krause & Son ADDRESS 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91205

CERTIFICATE OF DEATH.

24-08 D 91205

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer Hospital Bath ST., 20 WARD)

2-FULL NAME Chas. A. Heil

(a) RESIDENCE No 300 S Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	2.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath City

PARENTS

10 NAME OF FATHER Chas Heil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ella E. Heil
(Address) 300 S. Payson St.

OCT 20 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ (inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

a few minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H. B. Loughlin M. D.
(Coroner.)

Oct 20, 1924 (Address) 917 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Myer. Cathedral	Oct. 22 1924
20 UNDERTAKER George L. Schwab	ADDRESS 1101 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91206

CERTIFICATE OF DEATH.

129 D 91206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 Scott ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Barclay

(a) RESIDENCE NO. 1148 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Engle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Barclay (Address) 1148 Scott St

15 OCT 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Oct 18, 1924, that I last saw her alive on Oct 18, 1924, and that death occurred, on the date stated above, at 5.20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 mos

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Emil H. Carl, M. D.

(Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 21 1924
20 UNDERTAKER George J. Smith	ADDRESS 1632 Harlem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91207

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Madison & Linden ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine R. Johnson

(a) RESIDENCE No. 1766 E. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Mr. John H. Johnson.

6 DATE OF BIRTH (month, day, and year) Mar 23 1857

7 AGE — Years: 67 — Months: 6 — Days: 24 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Catherine Johnson

(Address) 1766 E North Ave

OCT 2 0 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 6 1924 to Oct 17 1924.

that I last saw h alive on Oct 17 1924

and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Ventral Hernia —

Chronic Diffuse Nephritis

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Nephritis (Exanthem) (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 8 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) F. W. Kratz, M. D.

10-17 1924 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Oct 21st 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1125 E Hamnt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE at last birthday and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91208 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 S. Mount St., 19 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Johnston

(a) Residence No. 100 S. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 31st 1844

7-AGE. 80 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Moses Johnston

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Ann Logan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Geo. H. O'Hara

(Address) 100 S. Mount St.

15- (Filed) OCT 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

069

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 17, '24

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1924 to Oct 17 1924

that I last saw h. alive on Oct-16 1924

and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/20, 1924 (Address) 1729 E. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. Oct. 20 1924

20-UNDERTAKER. F. B. Keppert

ADDRESS 1850 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91209

D 91209

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2410 Woodbrook ST.: 13 WARD)

2-FULL NAME Sophia E Kriel

(a) RESIDENCE. No. 2400 Woodbrook ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J Frederick Kriel

6 DATE OF BIRTH (month, day, and year) May 20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER C. C. Wunnenwetsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pfeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant S. F. Kriel

(Address) 2410 Woodbrook

Filed OCT 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

Hawe.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1924, to date of death, 1924, that I last saw h-r alive on Oct. 18, 1924, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Ovarian Carcinoma

Influenza (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? ....Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) Finlay LeDain, M. D.

, 19 (Address) 824 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park burn	Oct 21 1924
20 UNDERTAKER	ADDRESS
W M Roulson	223 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S—400 Eks.

D 91210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Willow Ave (Gardenville) St., 27 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen M. Meyer

(a) Residence No. 19 Willow Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ WIFE of Wm. J. Meyer

6-DATE OF BIRTH (month, day and year) Oct 24 1875

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph Nasmith

11-BIRTHPLACE OF FATHER (city or ~~town~~) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Laughlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-Informant. William J. Meyer

Address. 19 Willow Ave

15-OCT 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-19-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 13, 1924 to Oct. 19, 1924.

that I last saw h~~e~~r alive on Oct. 18, 1924

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Explanatory

Did an operation precede death? yes Date of Oct 1, 24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred H. Merman M. D.

, 19 (Address) 1013 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross G.A.Co.	10-22-24
20-UNDERTAKER.	**ADDRESS**
E & B Hasle	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—NAMES OF PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 91211 HEALTH DEPARTMENT—CITY OF BALTIMORE 141 D 91211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Marshall St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J. Geisler

(a) Residence No. 1705 Marshall St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Frank H Geisler

6-DATE OF BIRTH (month, day and year) May 11 1874

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Hundermark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) William Geisler

(Address) 1006 S Paca St

15- Filed OCT 20 1924 ROBERT P. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-18-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1924 to Oct 18 1924

that I last saw h~~er~~ alive on Oct 18 1924

and that death occurred, on the date stated above, at 12 45 ~~A~~ m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Infected & ulcerated complete prolapse of Uterus.

(Duration) yrs. — mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Stylles M. D.

10/20 1924 (Address) 440 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cem	10-20 1924
20-UNDERTAKER. James Dignan & Son	ADDRESS 1006 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAMES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Fulton Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Colm G Schwartz

(a) RESIDENCE NO. 520 N. Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Anna H Schwartz

6 DATE OF BIRTH (month, day, and year) Aug 20 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Grocerie 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Daniel Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Henrietta Baumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna H Schwartz (Address) 520 N Fulton Ave

15 OCT 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to Oct 18, 1924, that I last saw h alive on Oct 17, 1924 and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Heart

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) John F Crain, M. D.

, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	10-21 1924
20 UNDERTAKER Wm Chas A J Rohde	ADDRESS Washington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91213

CERTIFICATE OF DEATH.

D 91213

90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3216 E. Lombard ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin . Nowak

(a) RESIDENCE No. 3216 E. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	53	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr. William Weber Son In Law

(Address) 3216 E. Lombard Street

15 Filed OCT 20 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1924

17

I HEREBY CERTIFY, That I attended deceased from October 17, 1924, to October 17, 1924, that I last saw h/m alive on October 17, 1924 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edward A. Pilarski, M. D.

, 19 (Address) 431 S. Ellwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Rosary Cem. Oct 21 1924

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank St

D 91214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91214

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4223 Wickford Road ST.: 27 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delia Agnes Pickard

(Residence in Baltimore: No. 4223 Wickford Road St.: yrs., 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOW, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: Feb (Month) 2 (Day), 1861 (Year)

7-AGE: 63 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. G. Bullock

(Address) 4223 Wickford Road

OCT 20 1924

Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull due to Street Car Accident

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Morrison M. D. (Coroner.)

Oct 20, 1924 (Address) 3632 Rotunda Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL: Jamestown N. Y. DATE OF BURIAL, Oct 25 1924

20-UNDERTAKER: Chas. R. Traub & Son ADDRESS 1180 W. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91215

CERTIFICATE OF DEATH.

74-001

D 91215

REGISTERED NO.

1-PLACE OF DEATH Pronounced Dead at

CITY OF BALTIMORE: (No. Mercy Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M Higgins

(a) RESIDENCE No. 806 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Peddler
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed OCT 20 1924 192 ROBERT F. KRAUTER, Registrar

1877 Robert F. Krauter Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenlon, M. D. (Coroner.)

Oct 11 1924 (Address) York Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

OCT 20

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 91216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91216

CERTIFICATE OF DEATH.

Registered No. C [illegible]

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~[illegible]~~ On way from Central Police Station to Morgue St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lee

(Residence in Baltimore: No. unknown St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	unknown

6-DATE OF BIRTH.

..... (Month) ..... 1 ..... (Day) ..... (Year)

7-AGE.	If LESS than 1 day,
60 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed OCT 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

1873

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct ~~[illegible]~~ 13 ....., 192..4.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia -

Drug Addiction (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Kilby M. D.
(Coroner)

Oct 19 192~ (Address) 937 Druid Hill Ave

*State the **Disease Causing Death**, or, In deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
	....., 19....

20-UNDERTAKER, Per Wm. E. WOODALL | ADDRESS

OCT 20 1924

UNIVERSITY OF MARYLAND MEDICAL SCHOOL MORGUE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 91217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D 91217

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Walter Parker

(Residence in Baltimore: No. Inmate St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Inmate

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

OCT 20 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

1872

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13 24
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull -
accidentally fell from truck,
& into mobile - unconscious
(Duration) 8 hrs. yrs. mos. ds.
CONTRIBUTORY (Secondary) 2 days about
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
(Coroner.)
Oct 9 192 4 (Address) 1637 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

..... 19....

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91218

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2412 Maryland Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Bartlett Gove

(a) Residence No. 2412 Maryland Ave St., 12 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. 5 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Maynard A. Gove

6-DATE OF BIRTH (month, day and year): May-7-1860

7-AGE: 64 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Taxi

(c) Name of employer: Ellyman Taxi Co.

9-BIRTHPLACE (city or town) (State or Country): Boston mass.

PARENTS.

10-NAME OF FATHER: Charles Gove

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Boston Mass

12-MAIDEN NAME OF MOTHER: Sarah Mc Guire

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Boston Mass

14-(Informant): Mrs Nellie May Mills daughter

(Address): 2412 Maryland Ave

15-Filed OCT 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 5th, 19 24 to Oct 18th, 19 24

that I last saw h. ill alive on Oct 18th, 19 24

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Pericardial Effusion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frederick A. Gove M. D.

, 19 (Address) 2409 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Westerlimley — DATE OF BURIAL: Oct 20 19 24

20-UNDERTAKER: STEWART & HOWEN COMPANY (WILLIAM F. HOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91219

CERTIFICATE OF DEATH.

151 D 91219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2028 Keyser ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Greene

(a) RESIDENCE NO. 2028 Keyser ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Robert Greene

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 48; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Norfolk, Va.

PARENTS

10 NAME OF FATHER: Charles Doridge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Daughter

(Address): same

Filed OCT 20 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1924, to Oct. 17, 1924, that I last saw her alive on Oct. 17, 1924, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Moist gangrene of left foot

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Abrasion of great toe

(duration) yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M. D.

10/20/24 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alsbury Cemetery — DATE OF BURIAL: Oct 20 1924

20 UNDERTAKER: J Mus R G Elbert — ADDRESS: 1725 Eastland Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 91220

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1642 S. Charles St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Earley

(a) Residence No. 1642 S. Charles St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the Word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma S. Earley

6-DATE OF BIRTH (month, day and year) Oct 4 1860

7-AGE. 64 yrs. 0 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Crisfield Md.

PARENTS.

10-NAME OF FATHER, J. Earley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-Informant) Mrs. Emma S. Earley

(Address) 1642 S. Charles St.

15-Filed OCT 20 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10.18.24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1922, to Oct 18 19 24

that I last saw h. alive on 10/18 19 24

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. E. Burlington M. D.

10.19. 19 24 (Address) 102 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	10/21 19 24
20-UNDERTAKER.	**ADDRESS**
J. Fen McCully	130 E. Fort.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9122F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9122F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Strathmore Ave & Hosp. H Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Kelly

(a) Residence No. Strathmore Ave & Hosp. H St., Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John T. Kelly

6-DATE OF BIRTH (month, day and year): Nov 22-1887

7-AGE: 37 yrs. 10 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Washington D C

PARENTS.

10-NAME OF FATHER: Geo G. Donaldson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Margaret Hickey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant): John T. Kelly

(Address): Strathmore Ave & Hosp. H

OCT 20 1924 ROBERT R. KRAUTER, 19.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 18 1924

17- I HEREBY CERTIFY, That I attended deceased from November 1 19 23 to October 18 19 24, that I last saw h.. alive on October 18 19 24 and that death occurred, on the date stated above, at 11.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,
Chronic Recurrent Bronchitis.
(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocardial infarction (Duration) — yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray, sputum

(Signed) Chas. C. H. Johnston M. D.

, 19 (Address) 201 E. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19....
Loud Body	Oct 21 1924
20-UNDERTAKER,	ADDRESS
J. C. Wiedefeld	914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD. Every question should be carefully answered. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91222 HEALTH DEPARTMENT—CITY OF BALTIMORE 91222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 509 W. Saratoga St., 4 Ward) 161-01

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rogers

(a) Residence No. 509 W. Saratoga St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10-20-24

7-AGE. ... yrs. ... mos. ... ds.

If LESS than 1 day, 4 hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER Mathew Roden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Iowa.

12-MAIDEN NAME OF MOTHER Priscilla Rogers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Priscilla Rogers

(Address) 509 W. Saratoga

15- Filed 1924, 192... Registrar.

Burial Permit 1879

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from 10-20, 19 24, to 10-20, 19 24, that I last saw him alive on 10-20, 19 24, and that death occurred, on the date stated above, at 9 30 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) M. Alexander Mowry, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19...

20-UNDERTAKER. ADDRESS

JOHNS HOPKINS HOSPITAL

N.B.—WHITE PENCIL WRITING ON THIS CERTIFICATE IS PROHIBITED. WRITE PLAINLY WITH INDELIBLE INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91223 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91223

CERTIFICATE OF DEATH. 129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 E. Lombard St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Lena Silbergahn

(a) Residence No.... 1205 Ashland St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced ~~If (male)~~ WIFE of Henry Silbergahn

6-DATE OF BIRTH (month, day and year) Sept 12 1870

7-AGE, 53 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Philip Hoffman

11-BIRTHPLACE OF FATHER (city or town)..Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Anna Hunt

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant) Henry Silbergahn

(Address) 1205 Ashland Ave

15- Filed OCT 20 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Oct 18 1924

that I last saw her alive on Oct 18 1924

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease

unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Bernard Wells M. D.

10/19, 1924 (Address) 914 E. Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 21 1924
20-UNDERTAKER	ADDRESS
Edmund W. Conklin	924 E. Eager St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 12 Ward) Registered No. 74-201

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Cynthia Berry

(a) Residence No. 2014 Mace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Municipal Hospital Board

(Address)

15- Robert F. Harrison

Registrar.

OCT 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-16-24

17- I HEREBY CERTIFY, That I attended deceased from 7-16-, 1924, to 10-16, 1924

that I last saw h alive on 10-16, 1924

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension

Cerebral Hemorrhage (Right Hemiplegia)

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Immediate) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Clark G. Heron M. D.

10-16 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Oct 18 1924

20-UNDERTAKER. ADDRESS

F S Marshall 2539 Fall Rd

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact stated should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 91225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 91225

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1530 So Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie E Jones

(a) Residence No. 1530 So Charles St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry M

6-DATE OF BIRTH (month, day and year): Feb 19 1872

7-AGE. 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 131

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Thomas Pinkard

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Emmie Dickens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

11- (Informant) Mrs Jones

(Address) 1530 S. Charles

13-

OCT 20 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1923 to Oct 19 1924

that I last saw h[illegible] alive on Oct 19 1924

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? ✓

What test confirmed diagnosis? .....

(Signed) Emma Dr. Kahn M. D.

10/20, 1924 (Address) 3005 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Hunt Cr	Oct 23, 1924
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91226

CERTIFICATE OF DEATH.

1 90

D 91226

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 N. Ellwood Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Martin Schweiger

(a) Residence No. 514 N. Ellwood Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Henrietta Schwaiger

6-DATE OF BIRTH (month, day and year) March 7-1851

7-AGE.	If LESS than 1 day,
....73 yrs. ....7 mos. ....1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Schweiger

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Henrietta Brauns

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

11- (Informant) Margaret Hebner

(Address) 514 N. Ellwood Ave.

13- Robert P. Harrison, 192.....
Registrar.

Burial Permit Clerk.

CT 2 01324

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1924 to Oct 18 1924

that I last saw him alive on Oct 18 1924

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

, 1924 (Address) 3042 Hudson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem.	Oct 21, 1924
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 E. Lost St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 6 St., Ward)

Registered No. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Joseph Serve

(a) Residence No. 2612 Orleans St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct. 19, 1924

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 7 hrs. or 30 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Frederick Serve

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Buffalo, N.Y.

12-MAIDEN NAME OF MOTHER, Sophie J. Voigts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Philadelphia, Pa

14- (Informant) Frederick Serve

(Address) 2612 Orleans St

Robert P. Harrison, Registrar.

15- OCT 20 1924 192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 20. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1924 to Oct 20, 1924

that I last saw him alive on Oct. 19, 1924

and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) Roy Rhodes M. D.

, 19 (Address) St. Joseph Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	Oct 20, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander Sons	1710 Fleet St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91228

CERTIFICATE OF DEATH.

74 D 91228

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 E Fayette ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Miller

(a) RESIDENCE NO. 2506 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ (or) WIFE of Joseph Miller

6 DATE OF BIRTH (month, day, and year) Dec 29-1855

7 AGE 69 Years	Months 9	Days 18	If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Mc Heidaustman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Kone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Miller (Address) 2506 E Fayette st

15 Filed Oct 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Oct 18, 1924, that I last saw h alive on Oct 17, 1924 and that death occurred, on the date stated above, at 7 00 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lennard M. D.

10/21 1924 (Address) 7 1821 Pattersons Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 21 1924
20 UNDERTAKER	ADDRESS
Chas E. Miller & Son	2834 Gilford Ave

C 12 U 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91229 D 91229

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1038 Hanbert St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wittenberg

(a) Residence No. 1038 Hanbert St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Pauline Wittenberg

6-DATE OF BIRTH (month, day and year) March 26, 1871

7-AGE. 53 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Rapid Coal Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md.

PARENTS.

10-NAME OF FATHER. George Wittenberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Catherine ??

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Pauline Wittenberg

(Address) 1038 Hanbert

15- Filed OCT 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1924 to Oct 19 1924 that I last saw him alive on Oct 18 1924 and that death occurred, on the date stated above, at 8 30a m.

The CAUSE OF DEATH* was as follows:

Decompensated Mitral Regurgitation

(Duration) 1 yrs. 0 mos. 22 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no. Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos A Simms M. D

10/19 24 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross a cds — DATE OF BURIAL. 10-23 1924

20-UNDERTAKER. E & B Hale — ADDRESS 115 E Ves 8th

OCT 20 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91230

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH West Baltimore general Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Bayview Ave & Dukeland ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Joseph Thomas Birkshead

(a) RESIDENCE NO. 4808 Brightwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Birkshead.

6 DATE OF BIRTH (month, day, and year) March 17, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk. 109

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) maryland.

PARENTS

10 NAME OF FATHER Robert Birkshead

11 BIRTHPLACE OF FATHER (city or town) (State or country) maryland

12 MAIDEN NAME OF MOTHER Elvira Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) maryland

14 Informant (Address) Mrs Joseph A Birkshead 4808 Brightwood Ave

15 Robert L. Harrison, Registrar

19

OCT 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/16/ 1924. to 10/19/ 1924. that I last saw h(M)alive on 10/19/ 1924, and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis.

7 (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Paralytic Ileus. (duration) — yrs. — mos. 12 ~~days~~ hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/16/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical & operative

(Signed) G. Hunt Wilkinson M. D.

(Address) 10 Balto. Sun Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 10/21, 1924

20 UNDERTAKER John Funk & Bro

ADDRESS City

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Franke 1340 So Charles ✓

D 9123I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9123I

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Hait ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rickin

(a) RESIDENCE NO. 3302 Hait ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2. 1923

7 AGE — Years: — Months: 10 — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Bernard Rickin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriett Rickin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Bernard Rickin

(Address) 3302 Hait Ave

15 Dated ..... 19.. Registrar

OCT 20 1924

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1924, to Oct 20 1924.

that I last saw him alive on Oct 19 1924

and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) ... yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) ... yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Kielhorn, M. D.

. 19 (Address) 1340 S Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Oct 22 1924

20 UNDERTAKER: W. M. Cook — ADDRESS: 5028 York Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91232 ✓ D 91232

CERTIFICATE OF DEATH.

10

6

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Milliken ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest E. Chittenden

(a) RESIDENCE. NO. 1522 Milliken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Chittenden

11 BIRTHPLACE OF FATHER (city or town) Pittsfield
(State or country) Mass

12 MAIDEN NAME OF MOTHER Mary Lunsfeldy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Arthur Chittenden
(Address) 1522 Milliken St

15 Filed ....., 19....

Robert P. Harrison Registrar

CT 2 0 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 19, 1927, that I last saw him alive on Oct 19, 1927, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General diagnosis

(Signed) Adolph C. Eisenbeis, M. D.

Oct 20 1927 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Oct 21 1927
20 UNDERTAKER	ADDRESS
John Ullrich	2001 Orleans

N. B.—WRITE PLAINLY, WITH CARE. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 91233

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Emory Lister

(a) RESIDENCE No. 1558 Abbottson St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Lister

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Pearl Middleton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant W. H. Leight
(Address) 2923 Reese St.

15 Filed ..... 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CT20 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental-fell while jumping from roof of building to tree.
(Fractured Skull)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Weller, M. D.
(Coroner.)
10/20/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Piney Neck, Kent Co., Md.	10/21 192 4

20 UNDERTAKER	ADDRESS
H. W. Means & Son	805 W. Calvert St

VIA. AUTOMOBILE — W.H. LEIGHT - ESCORT

WRITE PLAINLY, WITH UNFADING INK. Obituary information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91234

CERTIFICATE OF DEATH.

129 D 91234

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Jefferson ST., 7 WARD)

2-FULL NAME Ida Lillian Railey

(a) RESIDENCE NO. 2326 Jefferson ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Clyde Railey

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 51; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): (37)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Ingle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Clyde Railey 2326 Jefferson St

15 Filed Robert P. Harrison, Registrar

CT 2 0 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19th 1924

17

I HEREBY CERTIFY, That I attended deceased from July 20th, 1924, to Oct 19th, 1924, that I last saw h[illegible] alive on Oct 19th, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Nephritis ? over

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary): Aortic Dilatation (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) L. M. C. Barker, M. D.

, 1924 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Oct 21/1924

20 UNDERTAKER: Wm C. Miller & Son

ADDRESS: 2324 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91235

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH: Callow Ave. & Lake Drive.

CITY OF BALTIMORE: (No.) Park View Apts. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Jennie Hayman.

(a) RESIDENCE NO. Park View Apts. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred: Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Leopold Hayman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Bettie Kronheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Solomon L. Hayman

(Address): Park View Apts.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/24. 19

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1923, to Oct. 20, 1924, that I last saw her alive on Oct 19, 1924 and that death occurred, on the date stated above, at 9.12 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (breast)

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Myocard Insuf.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Witness

Did an operation precede death? Yes Date of 6/19/23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam of tissue

(Signed) Eugene Hespe, M. D.

, 19 (Address) 20 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cheb Sholom Cemetery	10/22/24

20 UNDERTAKER: Isaac Sondheim ADDRESS 115-20 W. Mt. Royal Ave.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91236

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2 Roland Ave. Roland Park St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie A. Smith .....

(a) Residence No. 2 Roland Ave. Roland Park St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of William B. Smith

6-DATE OF BIRTH (month, day and year) January 27 1845

7-AGE,	If LESS than 1 day,
79 yrs. 8 mos. 21 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town). North East Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Charles T. Foster

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Robinson

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Dr. Robert L Mitchell
(Address) 2112 Maryland Ave.

15- Filed OCT 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 18, 1924, that I last saw h[illegible] alive on Oct 18, 1924, and that death occurred, on the date stated above, at 11.15 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Articular Rheumatism

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(Duration) 4 hours yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert L Mitchell M. D.

Oct 19, 1924 (Address) 2112 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Oct 21, 1924
Elkton, Maryland	
20-UNDERTAKER, Joseph L. Cook	ADDRESS No. 3 N. Eutaw St.

68.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 91237

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fairfield, Balto. Md 6 ST., ... WARD)

2-FULL NAME Charles A. Byus

(a) RESIDENCE NO 107 N. Elwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Byus

6 DATE OF BIRTH (month, day, and year) July 21/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Arundel Sand & Gravel Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stanley M. Byus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Byus
(Address) 107 N. Elwood Ave

Filed OCT 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fell overboard

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Oct 20, 1924. (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 21, 1924
20 UNDERTAKER	ADDRESS
H. Sander Sons	1310 Fed H

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91238

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1916 White St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Smallwood

(a) Residence No. 1916 White St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Thos Smallwood

6-DATE OF BIRTH (month, day and year) June 29 1861

7-AGE. 63 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Kent Co Md

PARENTS.

10-NAME OF FATHER. Richard Hopkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Amanda Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Thos. Smallwood

(Address) 1916 White Ave.

OCT 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/17/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1924, to Oct 17, 1924, that I last saw h. Es alive on Oct 17, 1924, and that death occurred, on the date stated above, at 930P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Disease

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) S. E. McCard M. D.

10/18, 1924 (Address) 1005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Hall Md | DATE OF BURIAL. Oct 21, 1924

20-UNDERTAKER. Edward Wheatley | ADDRESS 1128 Bolton St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91239

D 91239

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 N. Kincent ST. 15 WARD)

2-FULL NAME Lucy M. Hutton

(a) RESIDENCE. No. 1610 N. Kincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Hutton

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launderess

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Hattie Johnson, (Address) 532 Fulton Ave.

OCT 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1924, to Oct. 19, 1924, that I last saw h[illegible] alive on Oct. 18, 1924, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? History & Sputum.

(Signed) John D. Quinn, M. D.

10/20, 1924 (Address) 1077 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-22/1924
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pennsa Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91240

CERTIFICATE OF DEATH.

D 91240

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1234 S Sharp St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Butts.

(a) Residence No. 1234 S Sharp St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	—

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug-22-1922

7-AGE.	If LESS than 1 day,
2 yrs. 1 mos. 29 ds.	....hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Portsmouth Virginia

PARENTS.

10-NAME OF FATHER, Ernest Butts

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Portsmouth Virginia

12-MAIDEN NAME OF MOTHER, Annie B. Whittington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). U. A. Co Maryland

14- (Informant) Annie B Butts

(Address) 1234 S Sharp

15- Filed OCT 21 1924 By ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct, 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct, 16, 1924 to Oct, 20 1924 that I last saw h[illegible] alive on Oct, 19 1924 and that death occurred, on the date stated above, at 10a.m.

The CAUSE OF DEATH* was as follows:

acute bronchopneumonia

(Duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) whooping cough

(Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/20, 1924 (Address) [illegible] Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 1924
Mt Auburn Cem	10-21-
20-UNDERTAKER Samuel Perkins	ADDRESS 916 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91241

CERTIFICATE OF DEATH. X 129

D 91241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 W Biddle ST. 11 WARD)

2-FULL NAME Blanche Dyson Patterson

(a) RESIDENCE. No. Hospa Shamrock Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev Roderick Patterson

6 DATE OF BIRTH (month, day, and year) May 31 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles Dyson (Address) 1337 Fremont ave.

15 Filed ....., 19.... Registrar

OCT 21 1924

ROBERT R. KRAUTH,

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1924, to Oct 19, 1924, that I last saw h.. alive on Oct 19, 1924, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hypertension Chronic Nephritis

(duration) 12 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wilbur Hitchcock, M. D.

(Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Auburn

DATE OF BURIAL Oct 21 1924

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Lanvale ave

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91242

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 McCulloh ST., 13 WARD)

2-FULL NAME Susan Brown.

(a) RESIDENCE NO. 2509 McCulloh. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10 NAME OF FATHER Moses Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas.

12 MAIDEN NAME OF MOTHER Joanna Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Cornelia Cummings (Address) 25-09 McCulloch St

15 Filed OCT 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19- 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-10- , 1924 , to 10-19- , 1924 ,

that I last saw h alive on 10-17- , 1924 ,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. D. Cunningham, M. D.

10-20. 1924 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Oct 22 1924

20 UNDERTAKER J. Frow Hall

ADDRESS 753 Dolphin St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91243

CERTIFICATE OF DEATH.

D 91243

REGISTERED NO. 129 D 91243

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Liza Fraser

(a) RESIDENCE NO. 925 N. Amity ST. ~~ST.~~ WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Fuller Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records

(Address)

Filed OCT 21 1924, 19 ROBERT R. KRAUT, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 19, 1924, that I last saw her alive on Oct 19, 1924, and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - Hypertension - Arteriosclerosis

Symptoms (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen M.D.

19 1924 (Address) Johns Hopkins Hosp. Tel. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct. 22, 1924.
20 UNDERTAKER	ADDRESS 322 N. Schroeder St.
Mrs. Katie A. Williams	

Spec—12-23-21—E.B.R.S.—400 Eks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91244 — D 91244 Registered No.

1-PLACE OF DEATH Bay View Hospital 24 1848

City of BALTIMORE: (No. Bay View Asylum St., 24 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bailey

(a) Residence No. 1321 Cookie St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Will

6-DATE OF BIRTH (month, day and year) 1848

7-AGE	If LESS than 1 day
76 yrs. — mos. — ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS:

10-NAME OF FATHER Richard Bailey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14- (Informant) Hospital Records

(Address) Bay View Hospital

OCT 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 19-24.

17- I HEREBY CERTIFY, That I attended deceased from 9/29 19 24 to 10/19 1924.

that I last saw h[illegible] alive on 10/19 1924.

and that death occurred, on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Arthritis
2 Joints of Lower & upper
Extremities Terminating with
Ankylosis (Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho
Pneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wm. P. Champe M.D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Oct 22, 1924

20-UNDERTAKER	ADDRESS
Chas. L. Stevens	1501 E Fort Ave

Spec.—1-10-21 M&T 1500 Bks.

D 91245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91245

1-PLACE OF DEATH 2302 E. Oliver St

CITY OF BALTIMORE: (No. 2302 E. Oliver ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa M. Thomas

(a) RESIDENCE NO. 2302 E. Oliver ST., 8 WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Christian Thomas

6 DATE OF BIRTH (month, day, and year) May 7 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Mr. Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary E. Conroy

(Address) 2302 E. Oliver St

15 Filed OCT 21 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 20, 1924, that I last saw her alive on Oct 20, 1924 and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardeal Degeneration

Probably Coronary Thrombosis

(Sudden death)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allen Macdonald M. D.

Oct 20, 1924 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Octo 23 1924
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91246

CERTIFICATE OF DEATH.

D 91246

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 N. Durham ST., 8 WARD)

2-FULL NAME Clarence H. Collier

(a) RESIDENCE NO. 1702 N. Durham ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte M. Collier

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	40	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. H. Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Susan A. Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Charlotte M. Collier
(Address) 1702 N. Durham St.

15 Filed ..... 19..... Registrar

OCT 21 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 19. 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1922 to October 19th 24.

that I last saw him alive on October 19th 24.

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. — mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 24.

Was there an autopsy? No

What test confirmed diagnosis? Explor. Incision

(Signed) Thos. A. Meyer, M. D.

(Address) 103 N. Carlin ste.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery, DATE OF BURIAL: Oct. 22, 1924

20 UNDERTAKER: Wm. C. Black, ADDRESS: 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91247

CERTIFICATE OF DEATH.

1624

D 91247

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sachs

(Residence in Baltimore: No. 637 Cumberland St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. ....., 1 ..... (Month) (Day) (Year)

7-AGE. — — ....yrs....mos....ds. If LESS than 1 day, 4 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER. Carlo Sachs

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Edith Berman

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Sachs

(Address) 637 Cumberland St

15- OCT 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10- 20, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-20- 1924, to 10-20- 1924, that I saw him alive on 10-20- 1924, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Asphixia Neonatorum

.....

.....

..... (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Difficult delivery

Breech Presentation (Duration) ....yrs. ....mos. ....da.

(Signed) Dr Lewis Lai M. D.

10-20-, 1924. (Address) 11 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Friendship

DATE OF BURIAL, 10-21-, 1924

20-UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91248

CERTIFICATE OF DEATH.

31

D 91248

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal T.B. Hospital St., V V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edith Preston

(a) Residence No..... 29 S. Paca St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Examiner in factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Virginia Reed

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Municipal Hospital

(Address) Records.

15- OCT 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/18/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 19 24 to Oct 18 19 24

that I last saw h[illegible] alive on Oct 18, 19 24

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

Ind. Old Pelvoid T.B.

Uncertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) R. Schoof M. D.

10-20 1924 (Address) Municipal T.B. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL. Oct 21, 19 24

20-UNDERTAKER. Kraft & Son ADDRESS 1209 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D A K O

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 91249

1-PLACE OF DEATH

City of BALTIMORE: (No. 1119 S. Ellwood ave St. 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Sachs

(a) Residence No. 1119 S. Ellwood ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Sachs

6-DATE OF BIRTH (month, day and year) June 15-1858

7-AGE. 66 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Melchor Sachs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Madgelena Boell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Capt. John Sachs

(Address) 1119 S. Ellwood Ave

15-

Filed..... 192.. ROBERT A. KRAUTER, Registrar.

APR 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 19-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1924 to Oct 19 1924 that I last saw him alive on Oct 19 1924 and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

10/20. 1924 (Signed) Harvey B Fitchew M. D (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity Cemetery — DATE OF BURIAL, Oct 23 1924

20-UNDERTAKER, Zirkler + Zirkler — ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186-003

D 91250

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Lanvin Memorial Hosp St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miller M Fillmore

(Residence in Baltimore: No. 3688 Ash St St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (Write the word.)

6-DATE OF BIRTH: Nov 14 (Month) (Day) 1913 (Year)

7-AGE: 10 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS

10-NAME OF FATHER: Samuel Fillmore

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Annie McCauley

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Fillmore

(Address) 3688 Ash St

15-

OCT 21 1924

ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
Cause Auto accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J Morrissey M. D.
(Coroner.)

Oct 20 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 22 1924

20-UNDERTAKER: CHENOWETH & SON, 3617 CHESTNUT AVE. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

D 91251

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 91251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Duvall

(a) RESIDENCE NO. 2312 Boston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Duvall

6 DATE OF BIRTH (month, day, and year) May 15/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Canton Box Company

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. W. Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie M. Duvall (wife)
(Address) 3128 Elliott St.

15 Filed OCT 21 1924, 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intercranial Hemorrhage-confluent Pneumonia (Autopsy at hospital)
Accidental-Fell backwards out door 2nd floor white pulling truck loaded with boxes

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. Scott Collier, M. D. (Coroner.)

Oct 20/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct 22 1924

20 UNDERTAKER Robt G. Turner Jr. — ADDRESS 1702 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hartsook
16 18 Vasmuth

D 91252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 91252
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Montpelier ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linwood L. Cridlin

(a) RESIDENCE No. 1401 Montpelier ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Mary R. Cridlin

6 DATE OF BIRTH (month, day, and year) May - 1 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Cadillac Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER Jacob Cridlin
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Harriett Southard
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary R. Cridlin
(Address) 1401 Montpelier

15 Filed 19 Judith R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to October 20, 1924, that I last saw h. alive on October 17, 1924 and that death occurred, on the date stated above, at 8 10 a. m.

The CAUSE OF DEATH* was as follows:
Bright - Anemia

(duration) one yrs. mos ds.
CONTRIBUTORY (Secondary) Epithelioma
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? the usual test

(Signed) D Harry Hartsook, M. D.
19 (Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Oct 23 1924
20 UNDERTAKER William Cook	ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Blks.

D 91253 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 91253

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette W Payson ST., 15 WARD)

2-FULL NAME Mrs. Louise Coolahan

(a) RESIDENCE No. 2106 Chelsea Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced (or) WIFE of: Thomas Coolahan

6 DATE OF BIRTH (month, day, and year): — 1862

7 AGE: Years 62 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland Md

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cumberland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cumberland

14 Informant (Address): Mrs. Coolahan 2106 Chelsea Ter.

15 Filed ... 1924 HUBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from August 30th, 1924, to Oct. 20th, 1924, that I last saw her alive on Oct. 20th, 1924, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with general metastatic carcinomatosis

(duration) 2 yrs. + mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary edema & cardiac failure (duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. tests

(Signed) H. McDowell, M. D.

10/2/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Oct 23, 1924

20 UNDERTAKER: Ellis Leo[illegible] & Son

ADDRESS: [illegible]

Burial Permit Clerk

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91254

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 3017 Westwood Ave St., 15 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew Forbes

(a) Residence No. 3017 Westwood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Isabel

6-DATE OF BIRTH (month, day and year) Nov 6 1846

7-AGE. 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Foreman

(b) General nature of Industry, business, or establishment in which employed (or employer). 880

(c) Name of employer. .....

9-BIRTHPLACE (city or town) (State or Country). Ontario Canada

PARENTS.

10-NAME OF FATHER. John Forbes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14- (Informant) Mrs. E. Forbes

(Address) 3017 Westwood Ave

15- Filed ..... 192 HUBERT F. KRAUTER Registrar.

Burial Permit Clerk.

OCT 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct-20 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1924 to Oct. 20th 1924

that I last saw him alive on Oct. 19th 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Failure to rally properly after Pneumonia Septicemia 3 or 4 wks. ago. Immediate Cause of death was due to heart failure, there having been a valvular heart lesion present since 1917 & no doubt

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) H. St. J. O'Donovan M. D

10-20-1924 (Address) 3402 Wallbrook Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Forest	Oct 23 1924
20-UNDERTAKER.	ADDRESS
Edw. Lee & Son	E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91255

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ike Smith

(a) Residence No. Bay View Asylum St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 59 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Maryland (State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed OCT 21 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-17-24

17- I HEREBY CERTIFY, That I attended deceased from 10-11 1924 to 10-17 1924 that I last saw h— alive on 10-16 1924 and that death occurred, on the date stated above, at 5-50 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; C. N. S. Syphilis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab & Autopsy

(Signed) Claude C. Dent M. D.

10-17-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19....

20-UNDERTAKER. ADDRESS

OCT 21 1924

1885 Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 91256

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST., 4 WARD)

2-FULL NAME Baby Boy O'brien

(a) RESIDENCE NO. Lake Va. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Salto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Obrien

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eleanor Newsome

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Eleanor Obrien

(Address) Lake Va.

15 OCT 21 1924 Robert P. Harrison, ... 19 ..... Registrar

Burial Permit 18633

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1924, to Oct. 20, 1924, that I last saw him alive on Oct. 20, 1924, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Alexander Novey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

Bureau of Vital Statistics OCT 21 1924

Spec.—1-10-21—M&T—1500 Blks.

D 91257

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91257

CERTIFICATE OF DEATH. X 38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Mose Henderson

(a) RESIDENCE NO. 1355 N. Stricker ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None gd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Roanoke
(State or country) Va

PARENTS
10 NAME OF FATHER Jas. Henderson
11 BIRTHPLACE OF FATHER (city or town) Roanoke
(State or country) Va
12 MAIDEN NAME OF MOTHER Annie Davis
13 BIRTHPLACE OF MOTHER (city or town) Roanoke
(State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed Oct 21 1924, 19 Robert P. Harrison, 1882 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Oct 14, 1924, that I last saw him alive on Oct 14, 1924, and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:
Syphilis - Syphilitic of aorta - aortic insufficiency
Myocarditis & insufficiency.
Chr. Nephritis
(duration) yrs. 2 mos ... ds. Symptoms

CONTRIBUTORY (Secondary)
Cirrhosis (duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Trevor Owen, M. D.
Oct 19 1924 (Address) Johns Hopkins Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER ... Fisher Health, — ADDRESS OCT 21 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 21 1924

Cor.—1-12-23—M&T—100 Bks.

D 91258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 91258

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

I—PLACE OF DEATH

CITY OF BALTIMORE: (No 2020 Portugal ST., V WARD)

2—FULL NAME Martha Kuchnicka

(a) RESIDENCE No 2020 Portugal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Walenty Kuchnicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Chmielewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Walenty Kuchnicki.
(Address) 2020 Portugal St

15 Filed OCT 21 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Kenton, M. D.
(Coroner.)

Oct 21 1924 (Address) 700 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Oct 23, 1924.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 900 S. Ann

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91259

CERTIFICATE OF DEATH.

32

12

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2826 N. Calvert St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wilbert Kelley

(a) Residence No. 2826 N. Calvert St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6-DATE OF BIRTH (month, day and year) Aug. 19, 1901

7-AGE. 23 yrs. 2 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph J. Kelley

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Mahon

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Joseph J. Kelley (Address) 2826 N. Calvert St.

15- Filed ..... 192.....

OCT 21 1924 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 19-1924

I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1924 to Oct 19th 1924, that I last saw him alive on Oct 19th 1924 and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculous

(Duration) - yrs. - mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Do Not Know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture

(Signed) Frederick L. Grau, M. D.

, 19 (Address) 827 N. Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	10/22, 19 24

20-UNDERTAKER.	ADDRESS
Henry U. Mears & Son	805 N. Calvert St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91260

1-PLACE OF DEATH Hospital for the Women of Maryland

CITY OF BALTIMORE: (No. Lafayette & John Sts. ST., Block WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sadie Margaret Crockett

(a) RESIDENCE NO. Onancock, Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Joseph S. Crockett

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Accomac Co. Va.

PARENTS

10 NAME OF FATHER John W. Guy —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Accomac Co. Va.

12 MAIDEN NAME OF MOTHER Margaret Ayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Accomac Co. Va.

14 Informant: Mrs. Joseph S. Crockett (Address) Onancock Va.

15 OCT 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1924, to Oct. 21, 1924, that I last saw her alive on Oct. 21, 1924, and that death occurred, on the date stated above, at 2:17 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic Nephritis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myoma Uteri - Right inguinal hernia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown —

Did an operation precede death? Yes Date of Oct. 16, 1924

Was there an autopsy? No —

What test confirmed diagnosis? Physical Exam + Operation

(Signed) J. Clyde Mayfield, Jr., M. D.

, 19 (Address) Peninsula Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tasley Station Virginia

DATE OF BURIAL: Oct 21 1924

20 UNDERTAKER: H. Hopkins & Son Co

ADDRESS: Orchard & McCulloh Sts

WARNING—THIS IS A PERMANENT RECORD. Every item must be written PLAINLY, WITH UNFADING INK—Typewriting is preferable. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 Dexter ST. 71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Mc Keown

(a) RESIDENCE NO. 1145 Dexter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Timothy Mc Keown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winfred Mee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Mc Keown

(Address) 1145 Dexter St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

OCT 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) • 10/21/1924

17

I HEREBY CERTIFY, That I attended deceased from 10/21, 1924, to 10/21, 1924,

that I last saw h[illegible] alive on 10/21, 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilfred Dawson, M. D.

, 19 (Address) 1127 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, Harford Rd Cem.

DATE OF BURIAL 10/24 1924.

20 UNDERTAKER Wm Cook

ADDRESS 502 E Hoffman

MARGIN RESERVED FOR FILING. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 91262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91262

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 N. Calhoun St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F. Delkin

(a) Residence No. 314 N. Calhoun St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa E. Delkin

6-DATE OF BIRTH (month, day and year) Dec 24 1854

7-AGE, 69 yrs. 9 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frederick Delkin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Faul

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louisa E. Delkin

(Address) 314 N. Calhoun St.

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

OCT 2 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 19 24

17- I HEREBY CERTIFY, That I attended deceased from August 19th 1924 to October 19th 1924

that I last saw him alive on October 19th 1924

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of the Heart

Do not know (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) H. J. Carrick, M. D.

Oct 20, 1924 (Address) 412 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL, Oct 22, 1924

20-UNDERTAKER, Mrs. Mrs. John H. Temple & Son — ADDRESS 520 W Fayette St.

8.—WRITE PLAINLY, WITH UNFADING INK—THE ANSWERS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91263

CERTIFICATE OF DEATH.

90 D 91263

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1972 N Gay ST., 8 WARD)

2-FULL NAME Charles W Gelsendaffer

(a) RESIDENCE NO. 1972 N Gay ST., WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 1 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Gelsendaffer

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE 52 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Government

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Gelsendaffer

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanny Green

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Ireland

14 Informant Catherine Gelsendaffer
(Address) 1972 N Gay 8th

15 Filed ..... 19 ..... Robert P Harrison, Registrar
Burial Permit Clerk.

OCT 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 1924

17 Oct 19. 24

I HEREBY CERTIFY, That I attended deceased from May. 1. 23 19.... to Oct 19 19 24.

that I last saw h— alive on Oct 19 19 24.

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?

(Signed) William J Rysanek M. D.

Oct 21 19 24 (Address) 804 S Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 22 1924
20 UNDERTAKER	ADDRESS
Wm C. Miller & Son	2334 E Oliver

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91264

CERTIFICATE OF DEATH.

129 D 91264

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Eastern ave 1339 ST., 16 WARD)

2-FULL NAME William Frank

(a) RESIDENCE NO. Eastern ave 1339 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Frank

6 DATE OF BIRTH (month, day, and year) Dec. 8/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cmb Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C.A. Franks 066

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Gustav Frank

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Herring

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Edward Frank Jr
(Address) Eastern ave 1339

15 Filed OCT 21 1924 16 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Coroner death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Kinlon, M. D.
(Coroner.)

Oct 21 1924 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Oct. 24 1924

20 UNDERTAKER Mrs. C. Miller & Son — ADDRESS 2384 Gilmore St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 21 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91265

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1705 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Fillmore Webster Rodgers

(a) Residence No. 1705 Poplar Grove St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A. Rodgers

6-DATE OF BIRTH (month, day and year) June 21, 1892

7-AGE. 32 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Owner-Hauling

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland.

PARENTS.

10-NAME OF FATHER: John Monroe Rodgers

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Eliza Marsden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland

14-

(Informant) Mrs. F. A. Rodgers

(Address) 1705 Poplar Grove St

15-

Filed 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 5, 1924, to Oct 20, 1924, that I last saw him alive on Oct 20, 1924, and that death occurred, on the date stated above, at 5.08 Am.

The CAUSE OF DEATH* was as follows:

Pyemic Arthritis -
Septicaemia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Probable Tonsilar Infection, Scratching follicles clear with tip of finger nail (Duration) yrs. mos. ? ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of Oct 16, 24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Earl Wade, M. D.

10-20 24 (Address) 2020 N. Charles Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: Oct 22, 1924

20-UNDERTAKER: Joseph L. Cook — ADDRESS: 1003 N. Gilmor

CR B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CR 1 2

Cor.—1-12-23—M&T—100 Bks.

Vincent Wancowicz

D 91266

HEALTH DEPARTMENT—CITY OF BALTIMORE

118 ~ 002

D 91266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 610 S. Madeira ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Wancowicz

(a) RESIDENCE NO 510 S Madeira ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sophie Wancowicz

6 DATE OF BIRTH (month, day, and year) Sept 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer canning Co

9 BIRTHPLACE (city or town) (State or country) Poland Russia

PARENTS

10 NAME OF FATHER Paul Wancowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Smuks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Zelski
(Address) 1203 Eastern Ave

15 DATE RECEIVED OCT 21 1924 ROBERT R. KRAUTH Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation
Hanged

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Post operative

(duration) 7 yrs. ..... mos. ..... ds.

(Signed) Jno. M. Reuter, M. D.
(Coroner.)

Oct 20 1924 (Address) 700 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Oct 22 1924
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91267

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 Light St., 24 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Albert Wagner

(a) Residence No. 1001 Light St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary C. Wagner

6-DATE OF BIRTH (month, day and year): July 29 1849 ~~1924~~

7-AGE: 75 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Employee 013

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Co. Md.

PARENTS:

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-Informant: Florence Griffith

Address: 1001 Light St.

15-Filed OCT 22 1924 ROBERT R. KRAUTH, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 21 1924

17-I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 24 to Oct 21, 19 24 that I last saw him alive on Oct 20, 19 24 and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Asthma

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Lamm Lee M. D.

Oct 24, 1924 (Address) 1 E St Mass Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md (auto) DATE OF BURIAL: Oct 24, 1924

20-UNDERTAKER: John F. Denny ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 91268

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 16 WARD)

2-FULL NAME Robert E. Weaver.

(a) RESIDENCE No. 1626 N. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July. 4, 1924

7 AGE 0 Years 3 Months 15 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Leander Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rae Racusin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Leander Weaver.
(Address) 1629 N. Lanvale St.

15 OCT 22 1924 ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1924, to Oct 19, 1924, that I last saw him alive on Oct 19, 1924, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis. —

(duration) 0 yrs. 6 mos 15 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) 0 yrs. 3 mos. 15 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) M. D. Walsh, M. D.

, 19 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Oct 22 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91269
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1411 Ensor Street St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick J. Moore,

(a) Residence No. 1411 Ensor Street St., Ward
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow-ed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Moore

6-DATE OF BIRTH (month, day and year): 10/4/1860

7-AGE: 64 yrs. 0 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: James Moore

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant): Margaret Strickler
(Address): 1411 Ensor Street.

15- Filed OCT 22 1924 ROBT. S. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from July 5th 24 to Oct 21st 1924, that I last saw h live on Oct 19 1924 and that death occurred, on the date stated above, at 3-50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Urethralis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary): Cachexia

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno Stoner M. D.

Oct 22, 1924 (Address) 1501 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cemetery	10/24. 1924

20-UNDERTAKER: George J Ruth ADDRESS: 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91270 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

CERTIFICATE OF DEATH. 100 D 91270

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 S. Durham St., V Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Hisley .....

(a) Residence No. 605 S. Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Hisley

6-DATE OF BIRTH (month, day and year) March 1st 1856

7-AGE. 68 yrs. 7 mos. 18 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Last Employer City

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Joseph Hisley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Louisa Hisley

(Address) 605 S. Durham St.

15- Filed OCT 22 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 19/24

17- I HEREBY CERTIFY, That I attended deceased from Oct- 18- 1924 to Oct 18 1924

that I last saw h— alive on Oct 18 1924

and that death occurred, on the date stated above, at 5.30 P. M.

The CAUSE OF DEATH was as follows:

Broncho- Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Paul's Cemetery	Oct 22 1924
20-UNDERTAKER,	**ADDRESS**
H. Sander & Sons	1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91271

CERTIFICATE OF DEATH.

99-001 D 91271

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 435 N. Patterson Pk. Ave 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Straub

(a) Residence No. 435 N. Patterson Pk. Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Straub

6-DATE OF BIRTH (month, day and year) Feb. 8, 1840

7-AGE. 84 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown Grosbans

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mary V. Shawn
(Address) 435 N. Patterson Pk. Ave

15- Filed OCT 22 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924 to Oct 20, 1924 that I last saw h... alive on ..., 19... and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General diagnosis

Oct 21, 1924 (Signed) Adolph L. Leimbach M. D.
(Address) 2201-03 Oakdale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cemetery First Evangelical — DATE OF BURIAL, Oct. 23, 1924

20-UNDERTAKER. H. Sander & Sons — ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 91272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D 91272

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 1 WARD)

2-FULL NAME Sebastian Stock

(a) RESIDENCE NO. 3108 Elliott ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Stock.

6 DATE OF BIRTH (month, day, and year) Dec. 7-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0410

(b) General nature of industry, business, or establishment in which employed (or employer) Elliott Machine Co.

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Sebastian Stock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Gunther.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Stock.
(Address) 3108 Elliott St.

15 [illegible] 19 [illegible] ROBERT R. KRAUTER, Registrar

OCT 22 1924

Bureau of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1924

17

I HEREBY CERTIFY, That I attended deceased from 9/3, 1924, to 10/19, 1924, that I last saw him alive on 10/20, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

Lobular (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 10/11/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Dr. Isidor S. Fox, M. D.

Oct. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Oct. 23 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91273 D 91273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 626 Hanover St.

CITY OF BALTIMORE: (No. 1011 Denver St. ST., 21 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lawrence McKeldin, Jr.

(a) RESIDENCE NO. 1011 Denver ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis L. McKeldin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Grace Fraley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis L. McKeldin
(Address) 1011 Denver St.

OCT 22 1924
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Oct 21, 1924, that I last saw him alive on Oct 21, 1924, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1011 Denver St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. S. Reinicke, M. D.

Oct 24, 1924 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem — DATE OF BURIAL Oct 22, 1924

20 UNDERTAKER E. Schloman & Son — ADDRESS 1037 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91274

CERTIFICATE OF DEATH.

D 91274

389

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 16 WARD)

2-FULL NAME Jennie Ferguson

(a) RESIDENCE NO. Lombard ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...000...

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record
(Address)

15 Filed OCT 22 1924 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/24

17

I HEREBY CERTIFY, That I attended deceased from 10/14/24 to 10/20/24.

that I last saw h-alive on 10/20/24

and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH* was as follows:

Ileus (?)

Mitral Stenosis

Aortic Regurgitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk.	Oct 22. 24
20 UNDERTAKER Harry A. Weitzke	ADDRESS 1531 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91275

CERTIFICATE OF DEATH.

No 57

D 91275

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3823 Eastern Ave St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa R. Berkenkemper

(a) Residence No. 3823 Eastern Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ferd Berkenkemper

6-DATE OF BIRTH (month, day and year) 6/13/1859

7-AGE, 65 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Conrad Moeller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Klotz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Ferdinand Berkenkemper

(Address) 3823 Eastern Ave

15- OCT 22 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/20/1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 19 24 to Oct 20, 19 24

that I last saw h alive on Oct 20, 19 24

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alex H Sage M. D.

10/21/24 (Address) 706 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Pauls Reformed	Oct 23, 1924
20-UNDERTAKER, John Ulrich	ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be carefully answered. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1855

D 91276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lanvale & Catr. Grn ST., 27 WARD)

2-FULL NAME Albert Potts

(a) RESIDENCE NO. 1722 Johnson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Potts

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 0401
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Potts

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Potts (Address) 1722 Johnson

15 Filed OCT 22 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull

Contusion Cause Probably accidental fall on street

11 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner)

Oct 21, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., 11 mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 22 1924
20 UNDERTAKER J. Fenw McCully	ADDRESS 130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. FIGURES answering to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 91277

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 N. Carey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora V. Bradley

(a) Residence No. 310 N. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo W. Bradley

6-DATE OF BIRTH (month, day and year) Mch 12-1867

7-AGE, 57 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... home duties

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Virginia
(State or Country),

PARENTS.

10-NAME OF FATHER, Chas. F. Cox

11-BIRTHPLACE OF FATHER (city or town)..... Va
(State or Country),

12-MAIDEN NAME OF MOTHER, Cecelia Cox

13-BIRTHPLACE OF MOTHER (city or town)..... Va
(State or Country),

14- (Informant)..... Ruth C. Schumann

(Address)..... 310 N. Carey St.

15- Filed OCT 22 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 21. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 8 1924 to Oct. 21 — 1924 that I last saw her alive on Oct. 21 1924, and that death occurred, on the date stated above, at 6.25 P.M. The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) over 5 yrs. 5 mos. 13 ds.

CONTRIBUTORY (Secondary) None

(Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Coyle M. D.

Oct 21. 1924 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Alexandria Va.	Oct 24..., 1924
20-UNDERTAKER.	**ADDRESS**
John A. Mitchell	120 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91278

CERTIFICATE OF DEATH.

D 91278

REGISTERED NO. 2231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Williams

(a) RESIDENCE NO. 640 W. Lee st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Belle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

OCT 22 1924

(Filed) ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1924, to Oct. 20, 1924, that I last saw him alive on Oct. 20, 1924, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Pulmonary oedema (duration) yrs. Unknown mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

10-22-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 22 1924
20 UNDERTAKER	ADDRESS
Sam'l Chase Est	400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91279

CERTIFICATE OF DEATH.

74-001

D. 91279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 N. Stockton St., 16 WARD)

REGISTERED No. 91279

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tabbie Carter

(a) RESIDENCE NO. 1036 N. Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 0/0

9 BIRTHPLACE (city or town) (State or country) Lancaster, Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Cynthia Carter (Address) 1036 Stockton St.

Filed OCT 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history!

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

(Address) 2802 Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Bm	Oct 22 1924

20 UNDERTAKER Sam. W. Rawlings ADDRESS 400 Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91280 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hosp

CITY OF BALTIMORE: (No. ..... ST. 5 WARD)

REGISTERED NO. 74-031

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Weinstein

(a) RESIDENCE NO. 1206 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Weinstein

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Julius Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Weinstein

(Address) 110 S Broadway

15 Filed OCT 22 1924 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Oct. 21, 1924, that I last saw him alive on Oct. 21, 1924 and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

2 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hem.

3 days (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Isidor D. Fry, M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 10/22 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91281 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Hebrew Friendly Home 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abram Hyman Hagenheim

(a) Residence No. 249 Broad Street, Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Freida Hagenheim

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 180
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Dave Hyman
(Address) 2808 Eberman Ave

15-
Filed ..... 192.. ROBERT R. KRAUSE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 19/24

17- I HEREBY CERTIFY, That I attended deceased from June 1923 to Oct 19 1924 that I last saw h. alive on Oct 19 1924 and that death occurred, on the date stated above, at 12 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Whitehouse, M. D.

, 19 (Address) 1810 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Friendly Home	Oct 22, 19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Baltimore St

1924 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE B 91282

D 91282

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Hudson ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH ANUSZEWSKI,

(a) RESIDENCE NO. 2616 Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 36 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Anuszewski,

6 DATE OF BIRTH (month, day, and year) March 19-1845.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Daylaborer,

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER *****Anuszewski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Frances Anuszewska, (Address) 2616 Hudson Street

15 Filed OCT 22 1924 19 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 - 1924, to Oct. 22 1924.

that I last saw him alive on Oct 21, 1924

and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. S. Greer, M. D.

10/22 1924 (Address) 408 S Bat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. STANISLAUS CEMETERY — DATE OF BURIAL: OCT. 25. 1924

20 UNDERTAKER: M. J. Sadowski — ADDRESS: 405 S Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91283

CERTIFICATE OF DEATH.

D 91283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 59 Rueckert ave ST., Hamilton WARD)

2-FULL NAME George Kilian

(a) RESIDENCE NO. 59 Rueckert ave. ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcella L. Kilian

6 DATE OF BIRTH (month, day, and year) Dec. 9th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Kilian

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs Marcella L. Kilian (Address) 59 Rueckert Ave. Hamilton

15 Filed OCT 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Remarks

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 , 19 24 , to Oct 19 , 19 24 .

that I last saw h alive on Oct 19 , 19 24 ,

and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Gastro Haemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer of Stomach (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Palpable

(Signed) Chas Sauer , M. D.

19 24 (Address) 4206 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 23 24
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91284

CERTIFICATE OF DEATH.

179 D 91284

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gaines

(a) Residence No. 811 S Hanover St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1880

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) N. Carolina (State or Country),

PARENTS.

10-NAME OF FATHER, Watson Butler

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Record

(Address)

15- FILED OCT 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-18-24

17- I HEREBY CERTIFY, That I attended deceased from 10-15- 1924 to 10-18, 1924 that I last saw her alive on 10-18, 1924 and that death occurred, on the date stated above, at 1:30 P. m. The CAUSE OF DEATH* was as follows:

Hypertension; Chronic Nephritis; Myocardial Insufficiency

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY, (Secondary) Myocardial Failure

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sol. + Autopsy

(Signed) Claude S. Drew, M. D.

10-20 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
UNIVERSITY OF MARYLAND	19
20-UNDERTAKER, Commissioner of Health,	ADDRESS OCT 22 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

323

1888

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ellecamp

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91285

CERTIFICATE OF DEATH.

66

D 91285

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 N. Monroe ST.: 15 WARD)

2-FULL NAME Charles. Frederick Ellecamp.

(a) RESIDENCE. NO. 1823 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary E. Ellecamp

6 DATE OF BIRTH (month, day, and year) July 30 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Painting 050

(c) Name of employer Worked for H Grady Cumberland. Maryland.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Ellecamp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Chas. A Fetterhoff M.D.
(Address) 1807 W North Ave.

OCT 2 21924

ROBERT R. KRAUTER, Assistant
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Oct 20, 1924, that I last saw him alive on Oct 20, 1924, and that death occurred, on the date stated above, at 4.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism 5 years
(Haemmorhages)
Haemmorhages from stomach 1 day. (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paresis. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff, M. D.

, 19 (Address) 1807 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 23 24

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 N Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 91286

13 D 91286

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH
CITY OF BALTIMORE—No. 1246 Glyndon, Ave ST., 21 WARD)

2-FULL NAME Jno Wm Dash

(a) RESIDENCE No. 1246 Glyndon Ave ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 1924.

7 AGE — Years: — Months: 4 — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Dash

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jno Dash
(Address) 1246 Glyndon ave.

15 Filed OCT 2 1924 19.. HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/1924

17 I HEREBY CERTIFY, That I attended deceased from 10/21, 1924, to 10/21, 1924
that I last saw h.. alive on 10/21, 1924
and that death occurred, on the date stated above, at 11:30 a m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Improper Feeding
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Hubert A. Dash, M. D.

, 19 (Address) 1249 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 23 19 24

20 UNDERTAKER: John F. Feldmann — ADDRESS: 1200 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Done.

D 91287 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 91287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1117 Gen'l Hospt ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Geo W Cone

(a) RESIDENCE NO. 107 W Fay 22 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Emanuel Cone

6 DATE OF BIRTH (month, day, and year) June 2 1847

7 AGE Years 77 Months 4 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B&ORR. 013

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo D. Cone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo D Cone

(Address) 107 W Fayette

15 Filed OCT 22 1924 ROBERT R. KRAUSER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 22. 24

17 I HEREBY CERTIFY, That I attended deceased from 9. 16. 24, 19 , to 10. 22. 24, 19 .

that I last saw h alive on 10. 22. 24, 19

and that death occurred, on the date stated above, at 5.55 a m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Insufficiency

of Broken (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No Unnecessary

What test confirmed diagnosis? Clinical

(Signed) Wm A Tompkins, M. D.

Oct. 22 19 24 (Address) 107 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster

DATE OF BURIAL Oct 24 19 24

20 UNDERTAKER Wm J Williamson

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91288

CERTIFICATE OF DEATH.

71-005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Teresa Pfaff

(a) RESIDENCE No. 3105 Windsor Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J. J. Pfaff (dead)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Teresa Fortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mother Teresa M. Pfaff

(Address) 3105 Windsor Ave

OCT 22 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1924, to Oct 21, 1924, that I last saw her alive on Oct. 21, 1924, and that death occurred, on the date stated above, at 3 12 a m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis

Pneumococcic

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture-daily

(Signed) Myron G. Sill, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/22/1924
UNDERTAKER	ADDRESS
Chas. P. Crowe & Son	118 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

17 1698 D 91289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 135 D 91289

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME John Griffin

(a) RESIDENCE NO. Bethlehem ST., Caroline Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANSWERS to questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Griffin

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 - 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1924, to Oct 19, 1924, that I last saw him alive on Oct 19, 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy

(duration) 2 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Bethlehem, Md.

Did an operation precede death? Yes Date of 9-5-24.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Preston Md — DATE OF BURIAL Oct 22 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Aisq.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91290

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Thompson

(a) Residence No. 228 N. Glover St., 6 Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer). 884

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore, Md
(State or Country).

PARENTS.

10-NAME OF FATHER. Wm H. O. Thompson

11-BIRTHPLACE OF FATHER (city or town) N. J.
(State or Country).

12-MAIDEN NAME OF MOTHER. Annie ? Anderson

13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country).

14- (Informant) Municipal Hospital Record

(Address).....

15- Filed 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-21-24

17- I HEREBY CERTIFY, That I attended deceased from 10-16, 1924 to 10-21 1924 that I last saw him alive on 10-21, 1924 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis (Degenerative) Myocardial Insufficiency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Donnal M. D.

10-21, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Patricks Cemetery	Oct 25 1924
20-UNDERTAKER. Lilly Zeiler	ADDRESS 403 S. Wolfe St

N. B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Information should be in plain terms, so that it may be properly classified. Read carefully instructions on back of certificates.

D 91291

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 91291

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2101703 Aliceanna St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Baugert

(Residence in Baltimore: No. 706 S. East St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July (Month) 14 (Day) 1873 (Year)

7-AGE. 51 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Supt. 7
(b) General nature of industry, business, or establishment in which employed (or employer): Canning Co.

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER. John Baugert

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Anna Hoffa

13-BIRTHPLACE OF MOTHER, (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Baugert

(Address) 706 S. East ave

15- FILED OCT 22 1924 Robert P. Harrison, 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 20 (Day) 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) .....yrs. 5 mos.....ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) ? yrs.....mos.....ds.

(Signed) James M Fenton M. D. (Coroner.)

Oct 22 192.4 (Address) 700 E Clay

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn	Oct 24 192.4
20-UNDERTAKER, Lillye Zeibe	ADDRESS 407 N Wolfe St

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91292

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 N. Wolfe ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Mai Holmes

(a) RESIDENCE No. 1310 N. Wolfe ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-16-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1210 N. Wolfe Balto. Md.

PARENTS

10 NAME OF FATHER Vernon Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Lilly Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) 1325 Ashland Ave

15 Filed OCT 22 1924 Robert P. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-21, 1924, to 10-21-, 1924,

that I last saw her alive on 10-21-(AM), 1924,

and that death occurred, on the date stated above, at 4.P.M. m.

The CAUSE OF DEATH was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Error in Diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) J. H. Walters, M. D.

, 19 (Address) 1627 Ashland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery | DATE OF BURIAL Oct 22 1924

20 UNDERTAKER Harr R. A. Elliott | ADDRESS 1724 Ashland Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91293

D 91293

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jay Bis Ray.

(a) RESIDENCE NO. Johns Hopkins Hosp. ST. ..... WARD Burnsville N.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? 07 yrs. 3 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pansy Ray

6 DATE OF BIRTH (month, day, and year) June 27 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer and Judge

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self & Perhaps State of N.C.

9 BIRTHPLACE (city or town) (State or country) Burnsville N.C.

PARENTS

10 NAME OF FATHER Garrett Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Buckner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Records (Address)

15 OCT 22 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1924, to Oct 21, 1924, that I last saw him alive on Oct 21st, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis, Hypostasis pneumonia, Chronic Myocardial Insufficiency, Chronic Nephritis Uremia.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not able to say

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) Blas. Ld. Cumming M.D. M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burnsville - N.C.

DATE OF BURIAL Oct 22, 24

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T2

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91294 — B 91294

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Union Memorial Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Louis B. Crowley.

(a) RESIDENCE NO. 1684 Darley Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Florence M. Crowley (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Nov. 29-1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt Enamel Works

(b) General nature of industry, business, or establishment in which employed (or employer) 586

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER J Brooke Crowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Laura Bradt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Louis B Crowley
(Address) 1684 Darley Ave

15 Registrar Robert P. Harrison,

OCT 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1924, to October 21, 1924, that I last saw h— alive on October 21, 1924, and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

Ruptured Aortic Aneurysm.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Kidney Studies. Autopsy

(Signed) A. Austin Quarre, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Octo 24th 1924
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91295 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91295

101-901 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2925 Harlem Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Glorioso

(a) Residence No. 2925 Harlem Avenue St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6-DATE OF BIRTH (month, day and year): June 16, 1911

7-AGE: 13 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS:
10-NAME OF FATHER: Salvatore Glorioso
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12-MAIDEN NAME OF MOTHER: Angelina Culotta
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

11- (Informant): Salvatore Glorioso
(Address): 2925 Harlem Ave.

15- Filed OCT 22 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 21 24

17- I HEREBY CERTIFY, That I attended deceased from Octob 19 1924 to Octob 20 1924
that I last saw h[illegible] alive on Octob 20 1924
and that death occurred, on the date stated above, at 5.h. .m.
The CAUSE OF DEATH* was as follows:

Lob Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ~~Acute Colit~~ Bronchial Cold 2

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....

(Signed) Joseph L. Schnitker M. D.
Oct 22, 1924 (Address) 18 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	10/23 1924

20-UNDERTAKER	ADDRESS
George J Ruth	1735 HARFORD AV.

AH

S.S.—WRITE PLAINLY, WITH UNFADING INK. Cause of Death should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important, instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91296 ✓ D 91296

CERTIFICATE OF DEATH.

X 116

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland Steil. Hosp ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ridley

(a) RESIDENCE NO. Columbia Pike, Ellicott City, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ — yrs. — mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	negro	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 0

6 DATE OF BIRTH (month, day, and year) apr. 10, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Arundle Co., Md.

PARENTS

10 NAME OF FATHER Lewis Ridley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg, Va.

12 MAIDEN NAME OF MOTHER Elvira Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Paterson, N. J.

14 Informant Mother (Address) Columbia Pike, Ellicott city, Md

15 OCT 22 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1924, to 10/21, 1924, that I last saw him alive on Oct. 21, 1924, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/20/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 23 1924

20 UNDERTAKER Mrs Jas. H. Dennis per T. E. Nelson

ADDRESS 1303 Pressman St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91297

CERTIFICATE OF DEATH.

113 D 91297

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 971 N. Collington Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gloria [redacted] Deacon

(Residence in Baltimore: No. 971 N. Collington Ave St.; ..... yrs., 1 mos. 14 ds.)

WHITE REGISTRATION

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. (Month) 7 (Day), 1924 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, J. Herbert Deacon

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Loretta Bright

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Loretta Deacon

(Address) 971 N. Collington Ave

15-

Filed ....., 191.....

1924 Robert P. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 21 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I saw h..... alive on ..... 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Matthias Cemetery	Oct. 23, 1924
20-UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91298 ✓ 179 D 91298

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 Ridgely St., 9th WARD)

2-FULL NAME Catherine Morris

(a) RESIDENCE NO. 1240 Ridgely St, WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work (Probably) None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. Morris

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Durham

13 BIRTHPLACE OF MOTHER (city or town) Kent Co
(State or country)

14 Informant Mrs. Eva Greenwood
(Address)

15 10[illegible] 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CT 22 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Burns 3rd degree Flame of stove and burden (Duration) 1 hr. yrs. mos. ds.

CONTRIBUTORY (Secondary) Burden (duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Oct 22, 1924 (Address) (Coroner) 1137 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millington Md

DATE OF BURIAL Oct 23 1924

ADDRESS

20 UNDERTAKER F. A. Krause & Son 1037 Lemmon St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91299

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91299

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Ragner ave & Dukeland st ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie gaing.

(a) RESIDENCE NO. 1704 Mosher st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Vernon young.

6 DATE OF BIRTH (month, day, and year) April 3-1888

7 AGE 36 Years 6 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress. 041

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges co md.

PARENTS

10 NAME OF FATHER Thomas Carter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Georges co md.

12 MAIDEN NAME OF MOTHER Mary Brooks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Georges co md.

14 Informant Sister (Bertha Craig) (Address) 323 Mosher Ave

15 Filed OCT 21 1924 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924, to Oct 20, 1924, that I last saw h e alive on oct 20, 1924, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Chronic endocarditis

Chronic nephritis

About (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination & Laboratory

(Signed) Clement R. Monroe, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Greenmount Cem

20 UNDERTAKER Samuel W. Hennessey

DATE OF BURIAL Oct 23 1924

ADDRESS 578 W Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91300

CERTIFICATE OF DEATH.

129 D 91300

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Jas Parker

(a) RESIDENCE NO. 563 N. Mount St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Minister

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Nicholas Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harkrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Wesley Parker 1021 Madison Ave.

Robert P. harrison, Registrar

Burial Permit Clerk.

OCT 22 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Oct 20, 1924, that I last saw h[illegible] alive on Oct 20, 1924, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial d[illegible]
ency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Manning M. D.

Oct 24, 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Oct 22 1924

20 UNDERTAKER: Samuel Beasley ADDRESS: Eddie

WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED. PHYSICIANS should be careful to state exactly. AGE should be stated EXACTLY. PHYSICIANS should be careful to state exactly. mation should be carefully supplied. AGE, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91301 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E. Ware St. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Holland Jr

(a) RESIDENCE No. 11 E. Ware St., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis Holland

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE: Years 70; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Mary's Co Md

PARENTS

10 NAME OF FATHER: Lewis Holland Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lee Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Lewis Holland (Address) 11 Ward St

15 Filed OCT 2 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar Disease of Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrissey, M. D. (Coroner.)

Oct 22, 1924 (Address) 632 Rutland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. DATE OF BURIAL: Oct 23 1924

20 UNDERTAKER: Samuel Brushy ADDRESS: 1918 Bridge

mation should be carefully supplied. AGE should be stated EXACTLY. If child CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

Leazer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91302

D 91302

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Leazer

(a) Residence No. 430 Peach Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1868

7-AGE. 5-6 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER, Amos Leazer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. C

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. C

14-(Informant) Municipal Hospital Records

(Address)

Date Received OCT 23 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-20-24

17- I HEREBY CERTIFY, That I attended deceased from 10-20, 1924 to 10-20, 1924

that I last saw him alive on 10-20, 1924

and that death occurred, on the date stated above, at 5-20 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis; Myocardial insufficiency

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Brace M. D.

10-21, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Oct 24, 1924
20-UNDERTAKER. John H. Toadvine	ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH INK. OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91303

101-001

D 91303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Green ST. (Res.) 12th WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Royston

(a) RESIDENCE NO. 2815 Huntington ave. ST., ... WARD Room 218
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Royston

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edw. Royston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant University Hospital Road (Address)

15 Filed OCT 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1924 to Oct. 20. 1924.

that I last saw him alive on Oct. 20, 1924,

and that death occurred, on the date stated above, at 5 50 p. m.

The CAUSE OF DEATH* was as follows:

Prostectomy - which was complicated by atleo pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Oct. 14, 24

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. B. Whaley, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Oct 23 1924
20 UNDERTAKER	ADDRESS
A. S. Marshall	3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD IS PERMANENT. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91304

CERTIFICATE OF DEATH.

31 D 91304

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Archer ST., 21 WARD)

2-FULL NAME Ignacius Gray

(a) RESIDENCE NO. 616 Archer ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE — Years: 52 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Victor Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Brush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Charles Gray
(Address): 616 Archer St.

15 Filed OCT 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/21/1924

17 I HEREBY CERTIFY, That I attended deceased from 10/1/, 1924, to 10/21, 1924

that I last saw h[illegible] alive on 10/21/, 1924

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen A. Dean, M. D.

, 19 (Address) 1107 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ladychapel Putty Hill md — DATE OF BURIAL: Oct 25 1924

20 UNDERTAKER: J. H. Brown & Son — ADDRESS: Govans Manor

Spec.—1-10-21—M&T—1500 Bks.

D 91305 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-D 91305

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 Barnum Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Hazel

(a) RESIDENCE NO. 1241 Barnum Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? 88 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Robert F. Hazel

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	88	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Lionel Stevens ~~Hazel~~

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Martha M Briscoe

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co
(State or country) Md

14 Informant Walter C Bacon
(Address) 100 E 20th St.

15 OCT 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from ..., 1918, to Oct 21, 1924.

that I last saw her alive on Oct 21, 1924

and that death occurred, on the date stated above, at 9.26 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1241 Barnum

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Apoplexy

(Signed) Walter C Bacon, M. D.

10/22/1924 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem. DATE OF BURIAL Oct. 24 1924

20 UNDERTAKER Mrs. Albert E. Fuller ADDRESS Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91306

CERTIFICATE OF DEATH.

84 D 91306

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Dukeland ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Brenner or Bender

(a) RESIDENCE NO. 1000 Dukeland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	wh	married

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of Bertha Bender

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Meat Market
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Bender

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bender Bender

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Levis
(Address) 1139 Ensor St

15 OCT 2 31924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N.B.—Information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Kenney, M. D.
(Coroner.)

Oct. 23, 1924 (Address) 200 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reform Cemetery

DATE OF BURIAL Oct 25 1924

20 UNDERTAKER Jack Levis

ADDRESS 1139 Ensor St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91307 — 31 — D 91307

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 918 E. Madison, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Cooper

(a) RESIDENCE NO. 918 E Madison St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) N J

PARENTS

10 NAME OF FATHER Philip Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) N J

12 MAIDEN NAME OF MOTHER Anny Boggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address)

Rec'd OCT 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 21, 1924, that I last saw h alive on Oct 21, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute generalized miliary tuberculosis

(duration) yrs. mos. 7 1/5 ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin test & X-Ray

(Signed) Edward H Kerker, M. D.

10/21, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Ashury Cemetery — Oct 23 1924

20 UNDERTAKER — ADDRESS

Mac Ellis Elliott — 1726 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on hack of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91309

CERTIFICATE OF DEATH.

31

D 91308

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Francis Convent St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Daugherty

(Residence in Baltimore: No. 21 Francis Convent St.; 8 yrs., ... mos. ..... ds.)

Grace Convent Sts

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colord	Single

6-DATE OF BIRTH, March 8, 1909
(Month) (Day) (Year)

7-AGE, 15 yrs. 7 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): School Girl

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev Mother of the Convent

(Address) Cor of Hard Forest Place

15- Filed OCT 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1924, to Oct 1924, that I saw her alive on Oct 22 1924, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F Vaughan M. D.

Oct 23, 1924. (Address) 1022 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem — DATE OF BURIAL, Oct 24, 1924

20-UNDERTAKER Jas R A Elliott — ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. If CAUSE OF DEATH is vague or UNKNOWN it cannot be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91309

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 N. Duncan ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert A. Kline

(a) RESIDENCE No. 1835 N. Duncan St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Kline

6 DATE OF BIRTH (month, day, and year) Sept 17/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co Va
(State or country)

PARENTS

10 NAME OF FATHER Samuel Kline

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Tersa Greim

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Virginia Strocksy
(Address) 18~~67~~ N. Duncan St

Filed OCT 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(Probably Valvular)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. R. Watkins, M. D.
(Coroner.)

10/23/24 192 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 24 192 4
20 UNDERTAKER	ADDRESS
Richard E. Cooley	1101 Guilford

mation should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91310

D 91310

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isac Yanklof

(a) Residence No. 8 E. York St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca

6-DATE OF BIRTH (month, day and year) 10/22/24

7-AGE. 37 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Works in O+D meat store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER Jacob Yanklof

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rebecca Caplan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14-(Informant) Mrs Stern

(Address) 8 E York st

15-Filed OCT 23 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 22/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 1924 to Oct. 22 1924

that I last saw h. alive on Oct. 22 1924

and that death occurred, on the date stated above, at 10:55 P m.

The CAUSE OF DEATH* was as follows:

Gastric hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cancer stomach

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/or 24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) I. Clowes Cohn M. D

10/23 1924 (Address) St. Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Southern Cem

DATE OF BURIAL. 10/25 1924

20-UNDERTAKER. Sol Levinson & Bro

ADDRESS 1127 E Balto St

N. B.—WHITE PENCIL should be stated EXACTLY. PHYSICIANS should be careful in plain terms, so that it may be properly classified. See instructions on back of certificates. AGE should be carefully supplied. Exact statement of OCCUPATION is very important.

Spec 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91311

CERTIFICATE OF DEATH.

8 X 90

D 91311

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1515 E Lafayette Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Martha A. Bishop

(a) Residence No... 1515 E Lafayette Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Richard F Bishop

6-DATE OF BIRTH (month, day and year) Dec 18-1835

7-AGE, 88 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Harford Co-Maryland

PARENTS.

10-NAME OF FATHER, Thomas Strett

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Harford Co Maryland

12-MAIDEN NAME OF MOTHER, Jane Logue

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant)... Mrs Catonsville

(Address)... Catonsville Maryland

15-

Filed Oct 27 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 22-1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 1, 1924, to October 22, 1924 that I last saw h. alive on... October 20, 1924 and that death occurred, on the date stated above, at... 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

Oct 22 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cooptown Harford Co Md — DATE OF BURIAL, Oct 24 1924

20-UNDERTAKER, Charles E. Hornberger — ADDRESS Benson Md

N. B.—WHITE PENCIL MARKS ON DEATH CERTIFICATES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be specific in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93 D 91312

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1929 W. Franklin St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ernest E. Laplanche.....

(a) Residence No. 1929 W. Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Laplanche

6-DATE OF BIRTH (month, day and year) Nov. 4, 1860

7-AGE,	If LESS than 1 day,
63 yrs. 11 mos. 17 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mariner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) New Orleans
(State or Country), Louisana

PARENTS.

10-NAME OF FATHER, Paul F. Laplanche

11-BIRTHPLACE OF FATHER (city or town) Littry
(State or Country), France

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

14-

(Informant) Paul F. Laplanche Jr.

(Address) 1928 Penrose Ave.

OCT 23 1924

ROBERT R. KRAUTER,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 9, 1924 to Oct. 20, 1924

that I last saw him alive on Oct. 20, 1924, and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Embolism

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Multiple Phlebitis

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George C. Shannon, M. D.

10-22, 1924 (Address) 700 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem	Oct. 25 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Bath St

N. B.—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91313

74-007

D 91313

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melchizidek Wallace

(a) Residence No. 1416 Hanford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10-22-1878

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Nathan Wallace

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary E. McGlotten

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-(Informant) Municipal Hospital Records

(Address)

15-

Robert P. Harrison, Registrar.

Burial Permit Clerk

CT 23 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-21-24

17- I HEREBY CERTIFY, That I attended deceased from 10-20, 1924, to 10-21, 1924

that I last saw h~~im~~ alive on 10-20, 1924

and that death occurred, on the date stated above, at 3.15 ~~A~~ m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Cerebral Thrombosis (Left Hemiplegia)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sat + Autopsy

(Signed) Claude C. Dean M. D.

10-21 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Leakin Park	Oct. 24, 1924
20-UNDERTAKER	**ADDRESS**
Wm J. G. Locks	302 Jefferson St

WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. OCCUPATION is very important and should be properly classified. Exact statement of CAUSE OF DEATH should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Riley
B. Star

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91314

D 91314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3226 E. Balt. ST., WARD)

2-FULL NAME Ina Hines Smith

(a) RESIDENCE NO. 3226 E. Balt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Elizabeth

6 DATE OF BIRTH (month, day, and year) Sept. 1, 563

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	60	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) United P. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jack. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hagerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Martha Smith

(Address) 3226 E. Balto St.

15 Filed 1924 By Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-21 1924

17 I HEREBY CERTIFY, That I attended deceased from Some weeks ago to Oct. 19 24

that I last saw him alive on Oct 20 1924

and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows: Cirrhosis Pictoris

Some months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Oct. 24 1924 (Address) 1624 Bway, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lawn	Oct-24 1924
20 UNDERTAKER	ADDRESS
H. M. Cook	512 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 91315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91315

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Eutaw St. ST., | | WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Zahrendt,

(a) RESIDENCE NO. 511 N. Eutaw St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 10 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.,
(State or country)

PARENTS

10 NAME OF FATHER Chas. Zahrendt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Henry M. Lewis
(Address) 3101 Wyman Av.

Filed OCT 23 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry
(Inquest, autopsy or inquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Oct. 23, 1924 (Address) 2 Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 24 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. Numerals must be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91316

CERTIFICATE OF DEATH.

23 D 91316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N Fulton Ave. WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs May Roberts Harrison

(a) RESIDENCE. No. 413 N Fulton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John B Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary A Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wilbur F Harrison (Address) 413 Fulton Ave

15 Filed ..., 19... Robert P. Harrison, Registrar

CT 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct - 1 - 1924, to Oct - 23 1924, that I last saw h... alive on Oct - 23 1924, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs.

(duration) 2 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pittsburgh Eye & Ear Infirmary

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Martin M Smith, M. D.

(Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 25 1924
20 UNDERTAKER George J Smith	ADDRESS 153 L Hollins

N. B.—WRITE PLAINLY, ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91317

CERTIFICATE OF DEATH.

+ 101-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Agnes Connell.

(a) RESIDENCE NO. Spencer North Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER James C. Connell.

11 BIRTHPLACE OF FATHER (city or town) North Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Miss Dorie McCall.

13 BIRTHPLACE OF MOTHER (city or town) N. Carolina
(State or country)

14 Informant
(Address) Spencer, North Carolina.

15 Filed , 19 Registrar

CT2 31324 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23 1924.

17

I HEREBY CERTIFY, That I attended deceased from September 20, 1924, to October 23, 1924, that I last saw her alive on October 23, 1924, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia & Acute rheumatic fever.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? North Carolina (Coma)

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Austin Pearre, M. D.

, 19 (Address) Union Memorial Hosp. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Spencer, North Carolina	Oct 27, 1924
20 UNDERTAKER	ADDRESS
[illegible]	502 E. Fairmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

OCCUPATION

KODAK S.A.

Spec.—1-10-21—M&T—1500 Bks.

D 91318. 175-5

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Curtis G Kline

(a) RESIDENCE NO. 33 E 6th St ST., ... WARD

(Usual place of abode) Frederick, Md

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Kline

6 DATE OF BIRTH (month, day, and year) ? 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Foundary

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catharine Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) .....

15 OCT 23 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Oct 22, 1924, that I last saw him alive on Oct 22, 1924, and that death occurred, on the date stated above, at 12 5-8 pm.

The CAUSE OF DEATH* was as follows:

[redacted] Syphilitic gumma of trachea

(duration) yrs. mos. 21 ds.?

CONTRIBUTORY (Secondary) arising Rupture of carotid (duration) yrs. mos 2 minutes

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen, M. D.

Oct 23 1924 (Address) Johns Hopkins Hospital, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL Oct 25 1924

20 UNDERTAKER M. R. Etchison & Son

ADDRESS Fred. Md

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that NAME, AGE and DATE should be stated EXACTLY. Abbreviations should not be used. Information should be carefully supplied. Accuracy is important. Be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91319 (Comm Sta) D.S.R. CERTIFICATE OF DEATH. D 91319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Obtain Mean Balto ST., 12 WARD)

2-FULL NAME Hyman Feltenstein

(a) RESIDENCE NO. Gray Stone Hotel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Feltenstein

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fibre Hat Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer): manufacturing
(c) Name of employer: 086

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address): 1439 E Baltimore

15 Filed: DEC 23 1924, 192: Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 19 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Lesions

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner.), M. D.

12-23, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York (N. Y.)	12/23 1924

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of contributory TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91320

D 91320

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kasmier Chamielewski

(a) RESIDENCE No 2605 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) June 20 - 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Stephan Chamielewiski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Wanda Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Johns Hopkins Hospital
(Address)

Filed OCT 23 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.), M. D.

10/24/24 192 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 24 192 cl
20 UNDERTAKER	ADDRESS
F W Ozazewski	4320 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91321

CERTIFICATE OF DEATH.

90 D 91321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 Pierce st ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hulshimer

(a) RESIDENCE NO. 840 Pierce st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4c			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Elsie Carpenter
(Address) 616 W Lanvale St

15 Filed ..... 192 Robert P. Harrison, Registrar

CT 2 31924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said Inquest, ~~autopsy or inquiry.~~ find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis Heart Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct 23, 1924 (Address) 1117 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 10-25-1924

20 UNDERTAKER David Easton — ADDRESS Penn

U. S.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91322

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

91322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore general Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. Rayner Ave & Dukeland ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn mosley

(a) RESIDENCE No. 750 W. mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) 9-13-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of Industry, business, or establishment in which employed (or employer) infant

(c) Name of employer infant

9 BIRTHPLACE (city or town) Baltimore md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel mosley

11 BIRTHPLACE OF FATHER (city or town) Rock Hill
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Emma macral.

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant David Mosley
(Address) 750 W. Mulberry St.

15 Filed OCT 23 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/20/ , 1924 , to 10/22/ , 1924 ,

that I last saw h e alive on 10/22/ , 1924 ,

and that death occurred, on the date stated above, at 7:25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial - Pneumonia

5 (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) Clement P. Manuel, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-24-24
20 UNDERTAKER David Easton	ADDRESS 916 Ea ave

PHYSICIANS and Registrars of Births and Deaths.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 91323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1401 Smith ST., 16 WARD)

2-FULL NAME Evelyn Brayton

(a) RESIDENCE NO. 1401 Smith ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Brayton

6 DATE OF BIRTH (month, day, and year) Sept. 20 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	30	One	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Washing

(c) Name of employer General work

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Nutes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lewis J. Jackson (Address) 1401 Smith ST

15 Filed OCT 23 1924, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924.

17 I HEREBY CERTIFY, That I attended deceased from October 15 1924 to Oct 21 1924 that I last saw h[illegible] alive on Oct. 21 1924 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Charles E. Clark, M. D.

Oct. 23 1924 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

UNDERTAKER Daniel Carton

DATE OF BURIAL 10-25-24

ADDRESS 916 Penna ave

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 91324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91324

CERTIFICATE OF DEATH.

1-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1151 Myrtle Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Wallace.....

(a) Residence No. 1151 Myrtle Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 11 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 31 1901

7-AGE.	If LESS than 1 day,
22 yrs. 11 mos. 22 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or particular kind of work..... Sewing 069

(b) General nature of industry, business, or establishment in which employed (or employer)..... Overall Factory

(c) Name of employer..... Mr. Levin

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Saml Wallace

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Bedford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant)..... Same Spregat

(Address)..... 1151 Myrtle Ave

15- Filed..... 1924 Robt. F. Watkinson, Registrar.

CT 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 11th 1924 to Oct 22 1924, that I last saw h[illegible] alive on Oct 19th 1924, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

1 Typhoid Fever (Duration) — yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Edward Emil Jackson jr. M. D.

Oct 22, 1924 (Address) 1339 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 10-24 1924
Mt Auburn Cem	
20-UNDERTAKER. David Easton	ADDRESS 916 Penna Ave

B—WRITE PLAINLY. PHYSICIANS should state ONLY ONE CAUSE OF DEATH PER LINE. See instructions on back of certificates. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91325

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Bethel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Amos

(a) RESIDENCE. No. 1424 N Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Amos

6 DATE OF BIRTH (month, day, and year) 9/1/1859

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	65	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cath Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas F Steuart

(Address) 1424 N. Bethel St

15 Filed ..... 19 Robert P. Harrison, Registrar

OCT 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-16 1924, to 10-21 1924.

that I last saw her alive on 10-21 1924

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	10/24 1924
20 UNDERTAKER George J. Pulk	ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91326

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 20 S. Washington St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malgorzata Plichta

(a) Residence No. 20 S. Washington St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Homework

(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Wojciech Bachor

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Thomas Plichta

(Address) 20 S Washington

15- Filed ..... 192.. Registrar.

CT2 31924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 21. 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 19 24 to Oct 24 19 24

that I last saw h.. alive on Oct 21 19 24

and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... yrs. ..... mns. ..... ds.

CONTRIBUTORY (Secondary) Edema Lungs

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Oct 23. 1924 (Address) 937 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Hedwig's | DATE OF BURIAL, Oct 27 19 24

20-UNDERTAKER. William Fiaszowski | ADDRESS 847 Eastern Ave

NOTE—WRITE PLAINLY with pen and ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very particular to have all items correctly and properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. O'Donnell & 22nd St., 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Baranowski

(a) RESIDENCE No. O'Donnell & 22nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 6th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Baranowski

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Margaret Pozniak

13 BIRTHPLACE OF MOTHER (city or town) Balto City (State or country)

14 Informant Mary L Kruchowski (Address) O'Donnell & 22nd St

15 Filed Oct 23 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Suffocation While asleep

(duration) yrs. Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James W Fenton, M. D. (Coroner.)

Oct 23, 1924 (Address) 702 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cem. DATE OF BURIAL Oct 26 1924

20 UNDERTAKER J. J. Gallagher ADDRESS Woodlawn

THE CERTIFICATE OF DEATH must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state DEFINITELY. Indefinite and unscientific terms cannot be used. Omissions will DELAY BURIAL PERMIT. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 91328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Willow Spring Shore St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Henry Coulter

(a) Residence No. Willow Spring Shore St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Coulter.

6-DATE OF BIRTH (month, day and year) Jan. 19-1875

7-AGE. 49 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Asbestos

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Worker. 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Patrick Coulter

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Ireland

14- (Informant) Elizabeth Coulter

(Address) Willow Spring Shore

15- Filed OCT 23 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1924 to Oct 20 1924

that I last saw him alive on Oct 20 1924

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Stroke

Paralysis

(Duration) yrs. mos. 7 hrs

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Learmonth M. D

19 (Address) Dundalk, Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Boulster. Ft. Mary, Cem. N.J. DATE OF BURIAL. Oct. 24th 1924

20-UNDERTAKER. Tilly & Zeiler. ADDRESS 403 Lwofest

Should be carefully supplied. AGE should be stated EXACTLY. Physician's certificate is very important. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91329

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 929 N. Charles Street St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Lake

(a) Residence No. 929 N. Charles Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 8, 1846

7-AGE. 76 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James B. Lake

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Louisa H. Craig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Lewis Lake

(Address)

15- Filed 19 Robert P. Harrison, Registrar.

CT 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-22-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 16th 1924 to Oct 23rd 1924 that I last saw h[illegible] alive on Oct 20th 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell M. D

19 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery — DATE OF BURIAL. October 24, 1924

20-UNDERTAKER. E. LeRoy Stiffler — ADDRESS 125 E. North Ave

Note—Items must be carefully supplied. AGE should be stated EXACTLY. Physicians should be careful in filling out this certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Galeski)

Spec.—1-19-21—M&T—1500 Bks.

D 91330 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91330

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt general Hospital

CITY OF BALTIMORE: (No. Rayner Ave & Dukeland St. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolphe Zaleski.

(a) RESIDENCE NO. 1417 Reynolds St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mrs F. Zaleski.

6 DATE OF BIRTH (month, day, and year) June 12, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon keeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER James Zaleski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Cumnesky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Mrs. Martha Zaleski 1426 Reynolds st

15 Filed OCT 23 1924, 19 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/13/ , 1924. to 10/23/ , 1924.

that I last saw h/ alive on 10/23/ , 1924.

and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Septicemia. Endocarditis. (over)

3 weeks.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bilateral pneumonia
6 (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) Clement R. Monroe, M. D.

. 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. A.A.

DATE OF BURIAL Oct 25 19 24

20 UNDERTAKER Margaret L. Flynn

ADDRESS 442 Light St

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' and UNDERTAKERS' information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91331

58-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Falconer

(a) Residence No. 536 N. Arlington Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-~~Single,~~ Married, Widowed, or ~~Divorced,~~ (Write the word.) widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Leonora Ashwell

6-DATE OF BIRTH (month, day and year) Dec 5. 1851

7-AGE. 72 yrs. 10 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do not know

12-MAIDEN NAME OF MOTHER, do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " "

14-(Informant) John Falconer

(Address) 536 N. Arlington Ave.

15-Filed OCT 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/22/24

17- I HEREBY CERTIFY, That I attended deceased from 9/25 19.24 to 10/22 19.24

that I last saw him alive on 10/22 19.24

and that death occurred, on the date stated above, at 5 P .m.

The CAUSE OF DEATH* was as follows:

Banti's Splenomegaly

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? 0 Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) J. Clarence M. D

, 19 (Address) 704 Cathedral St

*State the **Disease Causing Death**, or In deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Oct 24 1924

20-UNDERTAKER John Oursler ADDRESS 120 W. Fayette

Should be carefully supplied. AGE should be stated EXACTLY. INFORMATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stanmore

D 91332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 B 91332

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 764 W Saratoga ST. 18 WARD)

2-FULL NAME George Arthur Stanmore

(a) RESIDENCE No. 764 W Saratoga ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE~~ of Lucy Elizabeth Stanmore

6 DATE OF BIRTH (month, day, and year) Jan. - 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
42	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in lumber yard

(b) General nature of industry, business, or establishment in which employed (or employer) Laying lumber

(c) Name of employer Mr. Potter, Wm. Lumber Co. 1 yrs

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER George Stanmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elizabeth Stanmore
(Address) 764 W. Saratoga St.

15 Filed OCT 24 1924 ROBERT P. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-1924

17 I HEREBY CERTIFY, That I attended deceased from 10/22, 1924 to 10/22, 1924 that I last saw him alive on 10/22, 1924 and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Cochran, M. D.

, 19 (Address) 818 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-26 1924
20 UNDERTAKER Samuel F Bruchy	ADDRESS 525 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91333

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 576 Preston St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Leonard Harkins

(a) Residence No.... 576 Preston St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Harkins

6-DATE OF BIRTH (month, day and year) Apr. 19 1868

7-AGE 56 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Paint dealer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 845

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Essex Co. Va.

PARENTS.

10-NAME OF FATHER. Geo. Harkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Robinson.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant) Mary E. Hastings

(Address) 576 Preston St.

15- Filed OCT 24 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 21 24

17- I HEREBY CERTIFY, That I attended deceased from ...January 4..., 19 23, to ...Oct. 21..., 19 24

that I last saw h... alive on ...Oct. 21..., 19 24

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Edema Nephritis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?..... No

What test confirmed diagnosis? Clinical Exam

(Signed) Edna E. Warren M. D.

10/13, 1924 (Address) 1618 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bethel Cemetery DATE OF BURIAL, Oct 23 1924

20-UNDERTAKER. Samuel Beasley ADDRESS 1 Biddle St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91334

CERTIFICATE OF DEATH.

73 D 91334

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Children's Hospital School 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen O'Connell.

(Residence in Baltimore: No. 907 Beaumont Ave., Govans St.; 3 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug. (Month) 30 (Day), 1921 (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John J. O'Connell, Jr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Florence Stegman

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. O'Connell Jr.

(Address) Govans

15-

Filed OCT 24 1924, 19.. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1924, to Oct. 22, 1924, that I saw her alive on Oct 22, 1924, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Shock following operations

Surgical Shock

(Duration) yrs. mos. 5 hours ds.

CONTRIBUTORY (Secondary) Malformed pylorus stenosis

(Duration) 13 yrs. mos. ds.

(Signed) Harold K. Bohlman M. D.

Oct. 23, 1924 (Address) Children's Hospital School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death? At place of death.

Former or usual residence 907 Beaumont Ave Baltimore

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, 10-27, 1924

20-UNDERTAKER Wm. Wade G. Rhode

ADDRESS 600 N. Arlington Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91335

CERTIFICATE OF DEATH.

51 D 91335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Hollins ST., 18 WARD)

2-FULL NAME Helen M. Connelly;

(a) RESIDENCE No. 1043 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) School Child,

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Frank A McConville,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Rose Plesner,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Rose McConville,
(Address) 1043 Hollins St.

15 Filed OCT 24 19 24 ROBERT R. KRAUTER, Registrar
Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22. 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27. 1924. to Oct. 22. 1924.

that I last saw her alive on Oct. 22. 1924;

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) X yrs. X mos 2 ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever,

(duration) X yrs. X mos. 26 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination.

(Signed) J. Chas. Conton, Jr. M. D.

10/23. 1924 (Address) 888 N. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Peter's

DATE OF BURIAL Oct 24 1924

20 UNDERTAKER John J Fields 17.20 W Fayette

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' and UNDERTAKERS' reports should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91336 — 129 — D 91336

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Clifton ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily K Bishop

(a) RESIDENCE NO. 1616 Clifton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 28 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edwd Comegys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co Md

12 MAIDEN NAME OF MOTHER: Kate A Comegys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co Md

14 Informant: Helen May Dowling

(Address) 1327 Mc Cue ave

15 Filed OCT 24 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1923, to Oct 22, 1924.

that I last saw her alive on Oct 22, 1924

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lloyd M.D.

, 19 (Address) 1123 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 25 1924

20 UNDERTAKER: Robert Brockett — ADDRESS: Calhoun & Hallins

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. All information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91337

CERTIFICATE OF DEATH.

90 D 91337

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 Linden Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isibella Greer

(a) Residence No. 1801 Linden Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 12 1842

7-AGE, 82 yrs. 7 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. John Greer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Isibella West

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Katherine Foresman

(Address) 1801 Linden Ave

OCT 24 1924 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924, to Oct 23, 1924, that I last saw h. alive on Oct 23, 1924, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Oedema of Lungs.

(Duration) 6 hours mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Queen, M. D.

, 19 (Address) 1733 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL, Oct 25, 1924

20-UNDERTAKER. George J. Smith — ADDRESS 753 Hollins

Please read carefully. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. Particular attention is called to the fact that OCCUPATION is very important. See that it is stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91338

CERTIFICATE OF DEATH.

D 91338
1-PLACE OF DEATH

Registered No. 90 D 91338

City of BALTIMORE: (No. 1111 S. Second St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Reese

(a) Residence No. 1111 S. Second St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj. Reese

6-DATE OF BIRTH (month, day and year): Oct. 12-1848.

7-AGE: 76 yrs. - mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Wales

PARENTS.

10-NAME OF FATHER: David Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14-
(Informant): Wm. D. Reese
(Address): 1111 S. Second St

15-
Filed OCT 24 1924 ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 22-1924

17- I HEREBY CERTIFY, That I attended deceased from October 22 1924 to Octob. 22 1924
that I last saw h[illegible] alive on Oct. 22 1924
and that death occurred, on the date stated above, at 6.30 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronstein M. D.

10-23 1924 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Oct. 25 1924
20-UNDERTAKER	**ADDRESS**
Zirkler + Zirkler	1739 E. Eager St.

N. B.—WHITE entries should be carefully supplied. AGE should be stated EXACTLY. INFORMANT should be identified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91339

CERTIFICATE OF DEATH.

D 91339

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2309 Elsinor Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice R. Hall

(a) Residence No. 2309 Elsinor Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Robt L. Hall

6-DATE OF BIRTH (month, day and year) Sept 27 1855

7-AGE. 69 yrs. — mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Chas Jn Reeder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Walter Hall

(Address) 2309 Elsinor ave

15-

Filed ..... 19.. Marshall S. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 23. 24

17- I HEREBY CERTIFY, That I attended deceased from July 20 1923 to Oct 23rd 1924 that I last saw h.. alive on Oct 22nd 1924 and that death occurred, on the date stated above, at 1-25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Colon

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W. A. Fair M. D.

10/23 1924 (Address) 136 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL. Oct 25 1924

20-UNDERTAKER. Josiah Lyter ADDRESS Woodsworth Ave

N. B.—WHITE PAPER. PRINTING. All items must be carefully filled. Exact statement of OCCUPATION is very important. Age should be stated EXACTLY. Physicians should be careful to write plainly. Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to write plainly. Name should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D 91340

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 N. Fulton Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Beekie Goldman

(a) Residence No.. 420 N. Chester St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Hyman Goldman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 431

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Jacob —

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Eastern

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Russia

14- (Informant) Jack Lewis

(Address) 1437 E. Baltimore St.

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/24/24

17- I HEREBY CERTIFY, That I attended deceased from April 1924 to Oct. 23 1924

that I last saw h[illegible] alive on Oct. 23 1924

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
General arteriosclerosis
Cardiac hypertrophy

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. A. Nicholson M. D.

10/25, 19 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel

DATE OF BURIAL. 10/27, 19 24

20-UNDERTAKER. Jack Lewis

ADDRESS 1437 E. Balto St.

WRITE PLAINLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91341

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Argyle ave ST.) (14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maltida Adams Jones.

(a) RESIDENCE. NO. 1402 Argyle ave. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Ezra L. Jones.

6 DATE OF BIRTH (month, day, and year) May 28. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER John Prescoe

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Viola Howard.

(Address) 1402 Argyle ave.

Filed OCT 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924. to Oct 21, 1924.

that I last saw h[illegible] alive on Oct 21, 1924

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular lesion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr symptoms

(Signed) Dr Washburne M. D.

10-22-1924 (Address) 733 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Oct. 24 1924

20 UNDERTAKER Mrs. Jas. H. Dennis

ADDRESS 1303 Pennsylvania Ave

Per Thomas E. Edelen

N. B.—WRITE PLAINLY WITH INK. PHYSICIAN should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Cor.—1-12-23—M&T—100 Bks.

91342

HEALTH DEPARTMENT—CITY OF BALTIMORE

90D 91342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Hearn ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Swann

(a) RESIDENCE NO. 431 Hearn ST., 17 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Feb. 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Lizzie Swann
(Address) 431 Hearn St

Filed OCT 24 1924 ROBERT M. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular
Disease of
Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

(Signed) John Lauterman, M. D.
(Coroner.)
Oct 24, 1924 (Address) 3632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashburn Cemetery	Oct 24 1924
20 UNDERTAKER J. Wade P. G. Elliott	ADDRESS 1725 Ashland

REMOVAL should be attended to promptly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91343

CERTIFICATE OF DEATH.

D 91343

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hospl St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank Owen Moran

(a) Residence No. 1225 Valley St., Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? 64 yrs. 6 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Grace Kurig Moran

6-DATE OF BIRTH (month, day and year) March 26 1860

7-AGE. 64 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk for

(b) General nature of industry, business, or establishment in which employed (or employer). Stewart Tapi Co

(c) Name of employer. (above)

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Patrick Moran

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Lane

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Grace King Moran (wife)

(Address) 1225 Valley St

15- Filed OCT 24 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 21-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 22, 1924, to Oct 21, 1924

that I last saw h. alive on Oct 21, 1924

and that death occurred, on the date stated above, at. 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Uremia and myocarditis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Cholecystitis

(Duration) 5 yrs. ' mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 16/24

Was there an autopsy? no

What test confirmed diagnosis? Phys & Clinical Ex

(Signed) Geo B Dyer, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Oct 25 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCC in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 91344

D 91344 REGISTERED NO.

1. PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Franklin Brooks

(a) RESIDENCE No. 2652 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1924

7 AGE Years 6 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Franklin Brooks

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Annie Mullen

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Frank Brooks (Address) 2652 Bernard St

15 Date Received OCT 24 1924 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1924, to 10-23, 1924, that I last saw h alive on 10-23, 1924, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Pyelitis - Acute -

Duration

CONTRIBUTORY (Secondary) Enterolitis - Acute Medic (duration) 1 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 24 1924

20 UNDERTAKER — ADDRESS

CHENOWETH & SON

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' mation should be carefully supplied. Exact statement of OCCU CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91345 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91345

CERTIFICATE OF DEATH. 112

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Penna ST., 17 WARD)

2-FULL NAME Logan Carter

(a) RESIDENCE NO. 1213 Penna Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15th 1900

7 AGE 24 Years 1 Months 9 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fishing
(b) General nature of industry, business, or establishment in which employed (or employer) Fisherman
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) north Thumberland Co Va

PARENTS

10 NAME OF FATHER Logan Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Carter
(Address) 1233 Penna Ave

Filed OCT 24 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1924, to Oct 23, 1924, that I last saw him alive on Oct 23, 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis (2 hours)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. N. Hatcher, M. D.

(Address) 1733 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 26 24

20 UNDERTAKER: Joseph a Harrell — ADDRESS: 2319 Pinkney

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should furnish information should be carefully supplied. Exact statement of OCCUPATION so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91346

CERTIFICATE OF DEATH.

178 D 91346

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute to St. Joseph Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mira Alsup

(a) RESIDENCE No 1619 Mulliken St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Bryan (Address) 1031 Orleans St

15 Filed OCT 24 1924 192 ROBERT R. KRAUEL Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22-1924 Oct 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Smoke Suffocation-residence burned

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. T. Owens, M. D.
(Coroner.)

10/22/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Mt Olivet Cemetery

DATE OF BURIAL
OCT 26 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1031 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91347

CERTIFICATE OF DEATH.

38 D 91347

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 408 N 5th St ST. Fairfield WARD)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 408 N 5th St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/23/24

7 AGE — Years | Months | Days | If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Jack Johnson

11 BIRTHPLACE OF FATHER (city or town) SC (State or country)

12 MAIDEN NAME OF MOTHER Matt White

13 BIRTHPLACE OF MOTHER (city or town) NC (State or country)

14 Informant Jack Johnson (Address) 408 N Fairfield Md

15 Filed ..... 19 ..... ROBERT B. KRAUTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/20 1924 to 10/23 1924

that I last saw h— alive on 10/23 1924

and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

(duration) — yrs. — mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. H. Augustus M. D.

, 19 (Address) 1340 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 10/24 1924

20 UNDERTAKER: Robert F Mulhain — ADDRESS: 1515 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION IS REQUIRED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 91348

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1775 (St.) Pinsidale (Ward) 24

2-FULL NAME Mary J. Sanford

(a) RESIDENCE NO. 1775 Pinsidale St. 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If ~~married~~, widowed, ~~or divorced~~

~~HUSBAND~~ of

(or) WIFE of James Sanford

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. J. Bailey

(Address) 1775 Pinsidale

OCT 24 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924, to Oct 22, 1924, that I last saw her alive on Oct 22, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic int nephritis uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? lab

(Signed) W. McClintock, M. D.

10/25 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	10/26 1924
20 UNDERTAKER	ADDRESS
J. J. Feeney & Sons	1318 Light St

N. B.—WRITE PLAINLY, WITH PEN AND INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91349

CERTIFICATE OF DEATH.

111-001

D 91349

Registered No.....

1-PLACE OF DEATH St. Joseph's Hospital

City of BALTIMORE: (No. ..... St., No ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Seipell Jr.

(a) Residence No. 316 S. Highland Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lula E. Seipell

6-DATE OF BIRTH (month, day and year) 6/27/1881

7-AGE. 43 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheet Straightner

(b) General nature of Industry, business, or establishment in which employed (or employer) Printing Office

(c) Name of employer No

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George A. Seipell, Jr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Emma Cessler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Md.

14-

(Informant) Harry Seipell

(Address) 1743 E. Lanvale Street

15-

Filed OCT 24 1924 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 23, 1924

17a I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924 to Oct 23, 1924

That I last saw him alive on Oct 23 1924

and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 22/24

Was there an autopsy? Yes

What test confirmed diagnosis? Hop. Clin. & the Operation

(Signed) Geo. B. Sykes M. D.

, 19 (Address) St. Joseph's Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	10/25, 1924

20-UNDERTAKER.	ADDRESS
Albert L. Hiltz Jr	1606 N. Chester St

N. B.—WRITE PLAINLY. Items must be filled EXACTLY. PHYSICIANS should be careful and particular. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Certificate should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91350

CERTIFICATE OF DEATH.

161-001

161 D 91350

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 104 N. Collington Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustavus A. Prescatt

(a) RESIDENCE No. 104 N. Collington Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna (Heisenbuttal) Prescott

6 DATE OF BIRTH (month, day, and year) March 3/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

031

9 BIRTHPLACE (city or town) (State or country) Charleston S.C.

PARENTS

10 NAME OF FATHER John Prescott

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Anna Prescott (wife)
(Address) 104 N. Col[illegible] ROBERT P. KRAUTER,

15 Filed OCT 24 1924 Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixation
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jos H Carter, M. D.
(Coroner.)

10/23/24, 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 25 1924
20 UNDERTAKER	ADDRESS
Columnah Coffin Co	1004 Argyle Ave

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 91351

91351 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Colbert

(a) RESIDENCE No. 2354 Poppleton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Colbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Beatrice Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Parent James Colbert

(Address) 235 E Poppleton

15 OCT 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Oct 22, 1924, that I last saw her alive on Oct 22, 1924, and that death occurred, on the date stated above, at 10 00 a m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis

Meningococcic

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Daily Lumbar puncture

(Signed) Myron G. Tull M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Oct 24th 1924

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood by the Health Officer. See instructions on back of certificates. IMPORTANT.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91352

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 91352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 N. Washington St. St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Engers

(a) Residence No. 613 N. Washington St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Single Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 25-1896

7-AGE. 27 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER. Charles Engers.

11-BIRTHPLACE OF FATHER (city or town) Balto.
(State or Country), Md.

12-MAIDEN NAME OF MOTHER. Anna Gier

13-BIRTHPLACE OF MOTHER (city or town) Balto.
(State or Country), Md.

14-
(Informant) Anna Engers.
(Address) 613 N. Washington St.

15-
Filed OCT 24 1924, 192.....
Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22-1924

17- I HEREBY CERTIFY, That I attended deceased from July, 1921 to Oct. 22nd 1924 that I last saw h[er] alive on Oct. 22nd 1924 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical Exam of Sputum

(Signed) A. T. Reis, M. D.

Oct. 23rd, 1924 (Address) 24 E. Mulberry

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Oct. 25th, 1924
20-UNDERTAKER.	**ADDRESS**
Tilly & Fuhrman.	403 S. Wolfe St.

CERTIFICATE OF DEATH. Must be filled in EXACTLY as required. PENCIL MARKS will not be accepted. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated EXACTLY in years, months and days. If LESS than 1 day, in hours or minutes. Write plainly. Use only black ink. Do not abbreviate. See instructions on back of certificates.

OK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91353

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 91353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 N. Durham St. St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Pfister

(a) Residence No. 7 N. Durham St. St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Pfister.

6-DATE OF BIRTH (month, day and year) Aug. 1851

7-AGE. 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto.

(State or Country) Md.

PARENTS

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) .....

(State or Country) Ger.

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (city or town) .....

(State or Country) Ger.

14-

(Informant) Michael Pfister

(Address) 7 N. Durham St.

15-

Registrar.

OCT 24 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20th 1924 to Oct. 22nd 1924

that I last saw her alive on Oct. 22nd 1924

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension & Senil. Art. disease

(Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. Spielberg M. D

10/25, 1924 (Address) 1616 E. Balto. St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Oct. 25 1924

20-UNDERTAKER. Lilly & Zeile ADDRESS 403 S. Wolfe St

BE WRITTEN EXACTLY. PHYSICIAN'S ... should be carefully supplied. AGE should be stated ... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91354

D 91354

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 E. Preston St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

2-FULL NAME C. Edward Rochester

(Residence in Baltimore: No. 2127 E Preston St.; 55 yrs., ... mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, August 5, 1869
(Month) (Day) (Year)

7-AGE, 55 yrs. ..... mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 673

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Rochester

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Julia Jones

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Bruce

(Address) 1235 Harford Ave.

15-

Filed ..... 191.. Registrar.

OCT 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, OCT 23 1924
(Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I attended deceased from AUG 2 - 1924 191, to OCT 2 3 1924 191,

that I saw him alive on OCT 2 3 1924 191,

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH was as follows:

General Toxemia after Operation for Perforated Ulcer of Stomach

(Duration) X yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. H. Duke M. D.

OCT 24 1924, 191.. (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct. ....., 1924

20-UNDERTAKER Henry Lutz

ADDRESS 1203 W. Broadway

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary to be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 91355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91355

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3040 Guilford Ave ST., 12 WARD)

2-FULL NAME Katharina Von Dreele

(a) RESIDENCE No. 3040 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Von Dreele

6 DATE OF BIRTH (month, day, and year) Jan. 18-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Phillip Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. K. H. Von Dreele (Address) 246 E. 36th St.

15 Robert P. Harrison Registrar

CT 24 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1924

17

I HEREBY CERTIFY, That I attended deceased from October 8, 1924, to October 23, 1924.

that I last saw h alive on October 23, 1924,

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Davies M. D.

10-27-1924 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct. 25 1924

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Falls Road

B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be careful. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91356

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Miss Josephine Carter

(a) RESIDENCE NO. 1622 John Street City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) London
(State or country) England

PARENTS

10 NAME OF FATHER S.Howell Carter

11 BIRTHPLACE OF FATHER (city or town) London
(State or country) England

12 MAIDEN NAME OF MOTHER Annie Field

13 BIRTHPLACE OF MOTHER (city or town) London
(State or country) England

14 Informant Miss Louise H.Carter
(Address) 1622 John St.

15 Filed ..... 19 ..... Robert P. Harrison
Registrar

OCT 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1924, to Oct 23, 1924, that I last saw h.r alive on Oct 23, 1924, and that death occurred, on the date stated above, at 1.30 pm.

The CAUSE OF DEATH* was as follows:

Myocarditis, Hypostatic Pneumonia,
Irreparable Lacerations of Cervix

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Irreparable Lacerations Cervix.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) L. W. Saunders, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	10-25-24 19
20 UNDERTAKER H.E.Hughes	ADDRESS 424 N.Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91357

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 N. Lakewood Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Insley

(a) RESIDENCE NO. 540 N. Lakewood Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

5a If ~~married~~ widowed, ~~or divorced~~
~~HUSBAND~~ OF
(or) WIFE of William H. Insley

6 DATE OF BIRTH (month, day, and year) Sept-11-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Stewart

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Keturah Stewart

13 BIRTHPLACE OF MOTHER (city or town) Dorcheater Co.
(State or country) Maryland

14 Informant Elizabeth K. Aharon
(Address) 540 N. Lakewood Ave

15 Filed OCT 24 1924, 19... Robert P. Garrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S ... mation should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1924, to Oct. 24, 1924, that I last saw h~~e~~r alive on Oct 23rd, 1924, and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage.

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) Coma (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert L. Kirk, M. D.

10/24/1924 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10-27-24
20 UNDERTAKER H.E. Hughes	ADDRESS 424 N. Broadway

Cor.—1-12-23—M&T—100 Bks.

D 91358 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91358

CERTIFICATE OF DEATH.

REGISTERED NO. 1853

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital ST., 18 WARD)

2-FULL NAME Charles Casper Labrowski

(a) RESIDENCE NO. 841 W Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Broom maker 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at Hospital

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant. Bay View Hospital Records
(Address)

15 Filed OCT 24 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Concussion of brain by fall down stairs in Hospital accident

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchi Pneumonia

(duration) yrs. mos. 3 ds.

(Signed) James M Hurlon, M. D. (Coroner)
Oct 24 1924 (Address) 701 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 2 yrs., 4 mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? at Hospital

Former or usual residence 841 W Fayette St

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 25 1924

20 UNDERTAKER George C Smith — ADDRESS 1532 Hollins

mation should be carefully supplied. Exact statement of ... that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it ...
TION is very important. See instructions on back of certificate.

D 91359

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

188 D 91359

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 18 E 21st St ..... St., 12 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G Rousseaux

(Residence in Baltimore: No. 18 E 21st St ..... St.; yrs. 35 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Married, ~~Widowed, Divorced~~ (Write the word.) Married

6-DATE OF BIRTH. Apl 29 (Month) ..... (Day) 1859 (Year)

7-AGE. 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sign Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050

9-BIRTHPLACE, (State or Country). New York

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Rousseax

(Address) 18 E 21 St

15- Filed OCT 24 1924 Robert P. Harrison, 19.. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Oct (Day) 22 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH was as follows:* Fractured Skull
Injuries Received
From Auto Accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John M. Louise M. D.
(Coroner.)

1924 (Address) 2132 R Cathedral

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cath[illegible] DATE OF BURIAL, Oct 25 24

20-UNDERTAKER, [illegible] ADDRESS CHENOWETH & SON 2617 CHESTNUT AVE

CT 24 1924

If CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY in terms of YEARS, MONTHS, DAYS, HOURS or MINUTES, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91360

CERTIFICATE OF DEATH.

D 91360

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Washington

(a) RESIDENCE No. Hyacinth Va ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... / House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Osborn Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hanna Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robert Brooks

(Address) Hyacinth Va

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk

OCT 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1924, to Oct 21, 1924, that I last saw h[illegible] alive on Oct 21, 1924, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

1 Diabetes Gangrene of Foot

2 Acute Cardiac Dilatation

(duration) ..... yrs. 0 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Oct 21-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A W Butler, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyacinth Va — DATE OF BURIAL Oct 25 1924

20 UNDERTAKER Harry H. Wittle — ADDRESS 531 W Lombard St

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. IMPORTANT. INFORMATION IS VERY important.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91361

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Bay View Asy Comm.

City of BALTIMORE: (No.) Bay View Hospital (St.) Dead A (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Aikens

(a) Residence No. 417 Asquith Street St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 3 mo. yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Black.

5-Single, ~~Married~~ Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of married

6-DATE OF BIRTH (month, day and year) 1885

7-AGE 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) South Carolina

PARENTS.

10-NAME OF FATHER Morton Aikens

11-BIRTHPLACE OF FATHER (city or town) (State or Country) South Carolina

12-MAIDEN NAME OF MOTHER Lyka (unknown)

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) South Carolina

11- (Informant) Hospital Records

(Address) Baltimore Md

15- Filed ..... 19.. Robert P. Harrison Registrar.

T 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 3, 1924, to Oct 23, 1924.

that I last saw h. alive on Oct 23, 1924

and that death occurred, on the date stated above, at 10.23 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach & Metastases Tertiary Lues.

(Duration) yrs. 2½ (History)

(Primary) Arteriosclerosis Fibrillation & acute

(Secondary) Myocardial Failure Pulmonary Oedema. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab Test

(Signed) Dr. P. Champe Jr. M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	Oct. 25 19.24
20-UNDERTAKER	ADDRESS
Wm J. G. Locks	1302 Jefferson

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. Particulars should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1604 St. Paul St., 17 Ward)

Registered No. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Lynch

(a) Residence No. 1604 St. Paul St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Lynch

6-DATE OF BIRTH (month, day and year) May 12, 1853

7-AGE.	If LESS than 1 day,
71 yrs. 5 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Richmond
(State or Country) Virginia

PARENTS:

10-NAME OF FATHER. Terence O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Murray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Mrs. A.M. Browning
(Address) 1604 St. Paul St.

15- Oct 25 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 24th

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1924 to Oct 24 1924

that I last saw h[illegible] alive on Oct 21 1924

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

Oct 25 1924 (Address) 700 E Chase

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	10/25, 1924

20-UNDERTAKER.	ADDRESS
Henry H. Mears & Son	805 N. Calvert St.

CT 25 1924

8.—MORTALITY STATISTICS ARE VALUABLE. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Habersaule

(a) RESIDENCE No. 3802 Ashburton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Kate Habersaule

6 DATE OF BIRTH (month, day, and year) Sept 24, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint grinder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penna (State or country)

PARENTS

10 NAME OF FATHER Chas Habersaule

11 BIRTHPLACE OF FATHER (city or town) Penna (State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Chas Habersaule

(Address) 3802 Ashburton Ave

Filed OCT 25 1924, 19

Robert F. Carroll, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24-1924

17

I HEREBY CERTIFY, That I attended deceased from , 1924 , to Oct. 24 , 1924 ,

that I last saw him alive on Oct. 24 , 1924 ,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix with Paresis of intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation 15 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Oct 21/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Dixon Gill, M. D.

, 19 (Address) 1 E. Mt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn

DATE OF BURIAL Oct 27 1924

20 UNDERTAKER Wm. J. Tichnor Sons

ADDRESS North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S name and address should be stated EXACTLY. PHYSICIAN should fill in all items. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91364

D 91364

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD) 14a

2-FULL NAME ~~Thomas Gilly~~ Somerville H. Foxwell

(a) RESIDENCE No. 608 N. Fulton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida M. Foxwell

6 DATE OF BIRTH (month, day, and year) June 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Murphy Furniture Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Zachariah Foxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lobilla Lateloun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Ida M. Foxwell

(Address) 608 N. Fulton Ave.

15 Filed OCT 25 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPERATIVE. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state mation should be carefully supplied. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Oct 24, 1924,

that I last saw h— alive on Oct 24, 1924,

and that death occurred, on the date stated above, at 9.55 a m.

The CAUSE OF DEATH* was as follows:

Malignancy at head of pancreas. "Carcinoma"; C

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteria-sclerosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 20. 24

Was there an autopsy? No: /

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Bernard L. Smith, M. D.

(Address) 1707 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Oct 29 1924

20 UNDERTAKER W. J. Pickuer & Sons — ADDRESS Norfolk Va

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91365

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3230 Toone St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Bortner

(a) Residence No. 3230 Toone St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fredericka Bortner

6-DATE OF BIRTH (month, day and year) Aug. 10 1869

7-AGE. 55 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill-wright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Brewsterv. Pa.

PARENTS.

10-NAME OF FATHER, Edward Bortner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Julia Amick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Fredericka Bortner

(Address) 3230 Toone St

15- Filed ..... 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 23-1924.

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to Oct 23 1924

that I last saw him alive on Oct 23 1924

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

& Oedema Lungs —

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reifschneider M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem — DATE OF BURIAL, Oct 27, 19 24

20-UNDERTAKER, Zirkler & Zirkler — ADDRESS 1739 E. Eager St

OCT 25 1924

M. 8—WRITE PLAINLY. PHYSICIAN'S should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very impor

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91426
D 91366

100-001
D 91366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Eagleston

(a) RESIDENCE NO. 122 N. Streeper St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8-1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Ernest Eagleston

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Gindrich

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address)

15 Filed 3 [illegible], 19 Robert P. Harrison Registrar,

Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' ATTENTION is called to the fact that the following information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be necessary to a correct understanding of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 -, 1924, to Oct 23 -, 1924, that I last saw h- alive on Oct 23, 1924, and that death occurred, on the date stated above, at 11 05 p.m.

The CAUSE OF DEATH* was as follows:
Intracranial hemorrhage - 15 days

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 122 N. Streeper St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund A. Kerper, M. D.
10/24/24
(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	10/25 1924
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91367

CERTIFICATE OF DEATH.

D 91367

1-PLACE OF DEATH

City of BALTIMORE: (No. 228 n Pine St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah Torrence

(a) Residence No. 228 n Pine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

~~Single~~, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Torrence

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Md (State or Country),

PARENTS.

10-NAME OF FATHER, Frank Turner

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Louisa Foden

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Henry Torrence

(Address) 228 N Pine St

15- (Date) 192 Robert P. Garrison, Registrar.

OCT 25 1924

Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/23/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 19 24 to Oct 23 19 24

that I last saw h[illegible] alive on Oct 22 19 24

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J B McCard M. D.

10/28, 19 (Address) 2005 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn — DATE OF BURIAL, Oct 26 19 24

20-UNDERTAKER. J. H. Brown & Son — ADDRESS 1626 Monument

WRITE PLAINLY. PHYSICIANS must see that all items are completed EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Myrtle Ave (St.) (WARD)

2-FULL NAME Ellen Desfields

(a) RESIDENCE No. 1427 Myrtle Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED No. 14D 91368

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Md. U.S.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Desfields
(Address): 1427 Myrtle Ave

15 Filed ... 1924 Robert P. Harrison, Registrar

CT 25 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct. 24, 192 4 (Address) 20 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 25 192 4

20 UNDERTAKER: Samuel Hensley

ADDRESS: 535 Bdle

mation should be carefully supplied. Exact statement of Occupation is necessary, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is necessary, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91369 D 91369

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH Howard a Kelly Hosp

CITY OF BALTIMORE: (No. 1418 Eutaw Pl. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie C. Cookus.

(a) RESIDENCE NO. Main, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Mr. Geo T. Cookus

6 DATE OF BIRTH (month, day, and year) Mar. 13-1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	07	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bunker Hill W. Va.

PARENTS

10 NAME OF FATHER Mr. Lewis R. Beeson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hopewell Va.

12 MAIDEN NAME OF MOTHER Lydia Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bunker Hill W. Va

14 Informant Hospital Record

(Address)

Robert P. Harrison, Registrar

Burial Permit Clerk.

OCT 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1924, to Oct 25, 1924.

that I last saw her alive on Oct. 25, 1924,

and that death occurred, on the date stated above, at 4.25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma thyroid.

(duration) 8? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation from hyperthyroidism (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Oct 23'24

Was there an autopsy? No

What test confirmed diagnosis? Pathological exam

(Signed) Grant E. Ward, J. Jr. M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charles Town W Va

DATE OF BURIAL 10-25 1924

20 UNDERTAKER E & B Hark

ADDRESS 115 E West St

N B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be properly classified. Exact state CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91370

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Battery Ave ST.: 24 WARD)

2-FULL NAME - Frederick H. Thuman

(a) RESIDENCE. NO. - 1140 Battery Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) - Nov. 15 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) - Bucks Ind

PARENTS

10 NAME OF FATHER - Bernard H. Thuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) - Bucks Ind

12 MAIDEN NAME OF MOTHER - Helen Rhinehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) - Germany

14 Informant - Bernard H. Thuman
(Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 . 1924 . to Oct 24 . 1924 . that I last saw h[illegible] alive on Oct 24 . 1924 . and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) - Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Oct 25 1924 (Address) 1211 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL - Holy Cross A & C — DATE OF BURIAL 10-25 1924

20 UNDERTAKER - Earl B. Hanke — ADDRESS 115 E West St

N.B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIAN'S NAME AND ADDRESS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

91371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B-003

B 91371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Virginia Avenue ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph S. Mc Williams Jr

(a) RESIDENCE NO. 609 Hollins Road ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph. Mc Williams

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Rose Poss

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Joseph Mc Williams
(Address) 609 Hollins Road

15 Filed ..... 192 .....
Robert P. Harrison,
Registrar
OCT 25 1924
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured skull
Auto accident

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Morrison, M. D.
(Coroner.)

Oct 25, 1924 (Address) 3672 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Oct 25 1924

20 UNDERTAKER Robt J Turner & Co — ADDRESS 1742 Broadway

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B.—WRITE PLAINLY, WITH UNFADING INK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91372

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-D 91372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 505 N Pulaski St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Friese

(a) Residence No. 505 N Pulaski St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Friese

6-DATE OF BIRTH (month, day and year) Jan 15th 1855

7-AGE, 64 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Daniel Friese

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germy.

12-MAIDEN NAME OF MOTHER. Fredericka Steiner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germy

14-(Informant) Minnie Friese

(Address) 505 N. Pulaski st

15-[illegible] 192.. Robert P. Harrison, Registrar.

Bur. [illegible]

CT 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 23-24.

17-I HEREBY CERTIFY, That I attended deceased from Oct 1 19 24 to Oct 23 19 24 that I last saw living on Oct 23 19 24 and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

10/25. 1924 (Signed) Bernard L. Grant M. D (Address) 1707 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Oct 27th 1924
20-UNDERTAKER.	ADDRESS
C. Schlosman & Son	1039 Hanover st

WHITE PENCIL—Entries must be typewritten or printed EXACTLY. PHYSICIAN'S NAME should be carefully supplied. AGE should be stated EXACTLY. Where exact information cannot be supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 Patterson Place ST., 8 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna ~~Fink~~ Finck

(a) RESIDENCE No 1930 Patterson Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C John Fink

6 DATE OF BIRTH (month, day, and year) Jan 18/1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	9	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. Hennick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Gruppe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mr. John C. Fink
(Address) 1930 Patterson Place

15 Filed OCT 25 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(Probable)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Pollitt, M. D.
(Coroner.)

10/23/24, 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Holy Redeemer Cemetery. Oct 27 1924

20 UNDERTAKER — ADDRESS
Kenny & Hoeck Son 1301 E Eager St

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91374

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91374

D 91874
17

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. M. ST., 8 WARD)

2-FULL NAME Emma Piersol

(a) RESIDENCE NO. 1114 N. Bond St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 7 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 109
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va.

PARENTS
10 NAME OF FATHER Charles Piersol
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Mary Wight
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924. to Oct 23, 1924.
that I last saw her alive on Oct 23, 1924,
and that death occurred, on the date stated above, at 5-15 p.m.

The CAUSE OF DEATH* was as follows:
Diabetes with Coma

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Wassermann Blood

(Signed) Manfred Sydenstricker M. D.
19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 27 1924

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful that NAME, AGE and CAUSE OF DEATH are stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91375

D 91375

CERTIFICATE OF DEATH.

REGISTERED NO. 1797

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 Stirling ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schnefer

(a) RESIDENCE NO. 967 Stirling ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Bartholomeus Schnefer.

6 DATE OF BIRTH (month, day, and year) May 19 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	59	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Denzlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Margaret Schnefer

(Address) 917 Stirling St

15 Filed ..., 19 ... Registrar

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1924, to Oct 25th, 1924, that I last saw h alive on Oct 25, 1924, and that death occurred, on the date stated above, at 1.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Endocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Typical of Labatory

What test confirmed diagnosis?

(Signed) J. M. Thomas, M. D.

Oct. 26 1924 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 28 1924
20 UNDERTAKER	ADDRESS
Henry Horch Son	1501 E Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS and UNDERTAKERS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified

Spec.—1-10-21—M&T—1500 Blks.

Magness 1203 E. Preston

D 91376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4023 Rathland Ave WARD) 5 - 129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha V. Myers

(a) RESIDENCE No. 4023 Rathland ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles H. Myers

6 DATE OF BIRTH (month, day, and year): May 22-1875

7 AGE: Years 49 Months 5 Days 2 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Pennsylvania

PARENTS

10 NAME OF FATHER: Charles Harkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Elizabeth Smart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Charles H. Myers

(Address): 4023 Rathland Ave

15 Filed ..... 19 .....

Burial Permit Clerk

OCT 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1924, to Oct. 24, 1924, that I last saw her alive on Oct. 23, 1924, and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lee Magness, M. D.

Oct 24, 19 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pa — DATE OF BURIAL: Oct 26, 1924

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Kelly, Burg + Kapnick

Cor.—1-12-23—M&T—100 Bks.

D 91377 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91377

CERTIFICATE OF DEATH.

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 South Fremont ST., 21 WARD)

2-FULL NAME John H Fivis

(a) RESIDENCE No 805 South Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a If married, widowed, or ~~divorced~~
HUSBAND of
(or) ~~WIFE~~ of Margaret Fivis

6 DATE OF BIRTH (month, day, and year) Apr 17, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Repairer 1/2
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward G. Fivis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant William M Fivis
(Address) 805 South Fremont St

15 Filed ..... 192 ..... Registrar
Robert F. Harrison,
Burial Permit Clerk

OCT 25 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of brain Skull fracture
Injuries of head & body
Accident (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Oct 24, 192 (Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Oct 25 192 4

20 UNDERTAKER J. W. Cook

ADDRESS 502 E Fayette Ave

Information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by a layman. See back of certificate. INFORMATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91378

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Simpson

(a) Residence No. 1055 Hillen St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 9-17 1847

7-AGE, 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City Hall

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Board

(Address)

15- Filed Oct 25 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-24-24

17- I HEREBY CERTIFY, That I attended deceased from 6-13, 1924 to 10-24, 1924, that I last saw him alive on 10-24, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis; Myocardial Insufficiency

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Drew, M. D.

10-24 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Oct 27, 1924

20-UNDERTAKER, Wm Leo Hill ADDRESS 201 E North Ave

Cor.—1-12-23—M&T—100 Bks.

D 91379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 SD 91379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Dallas Hall ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christiana Helder

(a) RESIDENCE NO 15-38 Latrobe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Helder

6 DATE OF BIRTH (month, day, and year) Sept 27/1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
60	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer) Germany
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER G. Evers

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Eliz. Keen
(Address) 1431 Gorsuch

15 Filed ....., 192.... Registrar

ROBERT P. MATTHEWS

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured liver
accidentally fell from room of her residence
Five hours (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage-Chest (duration) yrs. mos. ds.

(Signed) [illegible], M. D.
Oct. 24 192 4 (Address) (Coroner.) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Oct 27 192 4

20 UNDERTAKER John Selbrid

ADDRESS 2008 Eden

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91380 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91380

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount Ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Makubbin

(a) RESIDENCE No. 1005 Woodbine Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos A Makubbin

6 DATE OF BIRTH (month, day, and year) Mar 3/1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

137

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER C. A. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Thos A Makubbin

(Address) 1005 Woodbine Ave

15 Filed ....., 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 19 24, to Oct 24, 19 24,

that I last saw h alive on Oct 24, 19 24

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho - Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Above residence

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Kirtley Rose, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Oct 27/24

20 UNDERTAKER John Ulrich

ADDRESS 208 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91381 ✓

D 91381

CERTIFICATE OF DEATH.

590

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3802 Liberty Heights Ave. | 52 WARD)

2-FULL NAME Sarah E. Gill

(a) RESIDENCE NO. 3802 Liberty Heights Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Heithe S. Gill

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER ------ Beckley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Brooks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Edward M. Gill
(Address) 3802 Liberty Heights Ave.

15 Filed OCT 25 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12 - 1924, to Oct - 24, 1924

that I last saw h[illegible] alive on Oct - 24, 1924

and that death occurred, on the date stated above, at 10,20 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Heart (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Debilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marion W Shoaf, M. D.

10-24, 19 [illegible] (Address) 804 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 10/27 1924

20 UNDERTAKER Henry W. Spears & Son

ADDRESS 405 N. Calvert

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91382

CERTIFICATE OF DEATH.

B 91382

15 - 74 - B 01

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3310 Elgin Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella A. Phillips

(a) Residence No. 3310 Elgin Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

B—WRITE PLAINLY, with unfading ink. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the words)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. E. Phillips

6-DATE OF BIRTH (month, day and year) Sep't 3 1853

7-AGE. 71 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, William George

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary A. Maith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Miss Mabel Phillips

(Address) 3310 Elgin Ave.

15- Robert P. Harrison, 192..... Registrar.

CT 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from May - 9 1924 to Oct. 23 1924, that I last saw h[er] alive on Oct 22 — 1924, and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with right Hemiplegia. Last clonic attack with complete coma

(Duration) ....yrs. 5 mos. ....ds. R

CONTRIBUTORY —
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Clinical

(Signed) Frank Gall M. D.

10/23 1924 (Address) 2292 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	Oct 25 1924

20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91383

CERTIFICATE OF DEATH.

GD 91383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Johnson

(a) RESIDENCE No. 3142 S. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 65 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Police Dept. (Address) Northern Distr.

15 Filed OCT 25 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabulas
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Grant Morrison, M. D. (Coroner.)

Oct 25, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 26 1924
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	1254 North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

T25 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91384

D 91384

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Elsie Christian

(a) RESIDENCE NO. 723 S. Lakewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER James Christian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Tisa Denbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records JOHNS HOPKINS HOSPITAL ROBERT F. HARTSOCH, Burial Permit Clerk

(Address)

OCT 25 1924 , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924, to Oct 24, 1924, that I last saw h.. alive on Oct 24, 1924, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes What test confirmed diagnosis? Blood culture

(Signed) Trevor Owen, M. D.

Oct 24th, 1924 (Address) Johns Hopkins Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Humiston. DATE OF BURIAL Oct 28, 1924

20 UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann

GB.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS SHOULD WRITE. Name of deceased should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T- 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91385

CERTIFICATE OF DEATH.

D 91385

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2217 Linden Ave. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses H. Hirshberg.

(a) RESIDENCE NO. 2217 Linden Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Hirshberg.

6 DATE OF BIRTH (month, day, and year) July 7th. 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Paint Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 845

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Hirshberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Mr. Isidore Hirshberg
(Address) 2217 Linden Ave.

15 Robert P. Harrison, ... 19 ... Registrar
Burial Permit Clerk.

OCT 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/24. 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Oct 24, 1924, that I last saw him alive on Oct. 24 1924 and that death occurred, on the date stated above, at 9 45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis - myocarditis

(duration) ✓ yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

Oct 25 1924 (Address) 2040 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cemetery — DATE OF BURIAL: 10/26/ 1924

20 UNDERTAKER: David Sondheim — ADDRESS: 118-20 W. Mt. Royal Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 91386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91386

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 24 WARD)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ozman

(a) RESIDENCE NO. 1114 William St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1924

7 AGE Years Months Days — If LESS than 1 day 10 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Ozman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed OCT 25 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1924, to Oct. 21, 1924, that I last saw h[illegible] alive on Oct. 21, 1924, and that death occurred, on the date stated above, at 5.41 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Stone M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: OCT 25 1924

20 UNDERTAKER: Bureau of Health. — ADDRESS

Per Wm. F. McDALL

WRITE PLAINLY, WITH UNFADING INK—This [illegible] should be stated EXACTLY. PHYSICIANS should be careful that the information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

U.S.A. OCDA

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 91387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91387

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital) 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Louis B. Wingate .....

(a) Residence No. 10 S. Poppleton Street ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie M. Wingate

6-DATE OF BIRTH (month, day and year) Feb. 22nd, 1881

7-AGE.	If LESS than 1 day,
43 yrs. 8 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stove Repper

(b) General nature of industry, business, or establishment in which employed (or employer)..... (self)

(c) Name of employer.....

9-BIRTHPLACE (city or town) Lancaster County
(State or Country) Virginia

PARENTS.

10-NAME OF FATHER Napolian B. Wingate

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Elizabeth Hassard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14- (Informant) Mrs. Fannie M. Wingate

(Address) 10 S. Poppleton St.

15- Filed..... 19..... Registrar.

OCT 25 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1924 to Oct. 24, 1924 that I last saw him alive on Oct. 24, 1924 and that death occurred, on the date stated above, at 7.25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Chronic Alcoholism
Chronic Nephritis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physician, Laborat. Exam.

(Signed) Geo B Sybert, M. D.

10/24, 1924 (Address) St. Josephs Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Olivet Cemetery	Oct 27, 1924
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Gilmor St

N. B.—WRITE PLAINLY. WITH ONLY ONE ITEM in each space. All questions should be answered EXACTLY. PHYSICIAN'S MEDICAL STATEMENT should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. All questions should be properly answered. Exact statement of OCCUPATION is very important. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MEDICAL STATEMENT should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. All questions should be properly answered. Exact statement of OCCUPATION is very important. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MEDICAL STATEMENT should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. All questions should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91388

CERTIFICATE OF DEATH.

4 88316 D

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Park Heights ave. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Levin

(a) RESIDENCE. No. 4009 Park Heights ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Levin
(Address) 2280 Aisquith Street

15 Filed OCT 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1. 1924 to Oct 25. 1924

that I last saw b. alive on Oct 24 1924

and that death occurred, on the date stated above, at 6-15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall - Bladder Metastasis through abdomen & Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 8 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bug. finds

(Signed) James S. Kohnop, M. D.

10-25 1924 (Address) 4017 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Blvd

DATE OF BURIAL 10/ 1924

20 UNDERTAKER Jack Levin

ADDRESS 1434 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. AGE should be carefully supplied. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91389

CERTIFICATE OF DEATH.

100-001 ✓ D 91389

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 20 WARD)

2-FULL NAME Mrs Sam Silverstein

(a) RESIDENCE NO. 2104 Eagle street — ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	m	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Silverstein

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1409 E Baltimore St

15 Filed ..... 19 ..... Registrar
ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1924, to 10/26, 1924, that I last saw h alive on 10/26, 1924, and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure,

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of .....

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Dr. William [illegible], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodmere Cem

DATE OF BURIAL 10/28 1924

20 UNDERTAKER Jack Lewis 1409 E Baltimore St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91396

CERTIFICATE OF DEATH.

101-08 D 91390

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., ... WARD)

2-FULL NAME Harry Levin

(a) RESIDENCE NO. 236 N. Chester ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer .....

9 BIRTHPLACE (city or town) Brooklyn N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Levin

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Rosenfeld

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Husband Bernard
(Address)

15 Filed OCT 26 1924, 19.. ROBERT H. KINSTLER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25 19 24

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 19 24, to 10/25, 19 24, that I last saw h— alive on 10/25/24, and that death occurred, on the date stated above, at 11:10 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Pneumonia.

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

. 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 10/26 19 24

20 UNDERTAKER Jack Levy — ADDRESS 1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Israel Long

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91391

CERTIFICATE OF DEATH.

6 100-001 ✓

D 91391

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1922 E. Balto. St., ... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Israel Long.....

(a) Residence No.....1922 E. Baltimore St., ... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Rae Long

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
67 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Russia

14- (Informant).....J. Lewis.....
(Address).....1439 E. Balto. St.,.....

15- Filed OCT 26 1924, 19.... ROBERT R. KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-24-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1924 to Oct 24 1924

that I last saw h. alive on Oct 24 1924

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. X Baughman M. D.

10/25, 19 (Address) 210 E. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Memory Park	10/26, 19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91392

CERTIFICATE OF DEATH.

90 D 91392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 566 Mosher ST., 14 WARD)

2-FULL NAME Eleanor A Brown

(a) RESIDENCE No. 568 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Brown

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Charlottesville (State or country) Va

PARENTS

10 NAME OF FATHER Julius Coltrane

11 BIRTHPLACE OF FATHER (city or town) America (State or country) —

12 MAIDEN NAME OF MOTHER Dora Swingler

13 BIRTHPLACE OF MOTHER (city or town) Esmont (State or country) Va

14 Informant Joseph A Brown (Address) 568 Mosher St

15 Filed OCT 26 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 1924, to Oct. 24th, 1924, that I last saw h[illegible] alive on Oct 24th, 1924, and that death occurred, on the date stated above, at 11— a.m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

the Endocardium

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

Respiratory failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas Maxwell Hunt M. D.

L.R.C.P. L.R.C.S. (Edinburgh)

, 19 (Address) 1414 Argyle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Esmont Va — DATE OF BURIAL 10-26-24

20 UNDERTAKER Saml Easton — ADDRESS 916 Baum Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91393

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 91393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1351 Ward St., 71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Satchell

(a) Residence No. 1351 Ward St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thos A. Satchell

6-DATE OF BIRTH (month, day and year) 1884

7-AGE	If LESS than 1 day
40 yrs. — mos. — ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook 21

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer Franklin Sq. Hospital

9-BIRTHPLACE (city or town) (State or Country), Nat Co Md

PARENTS.

10-NAME OF FATHER, Joshua Cornish

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Nat Co Md

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Thomas A. Satchell

(Address) 1351 Ward St

15- Filed OCT 2 3 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 23, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924, to Oct 23, 1924, that I last saw h.e alive on Oct 21 st 1924, and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) — yrs. 7 mos. 10 ds.

CONTRIBUTORY (Secondary) Pelvic Abscess

(Duration) — yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of Feb & June 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edward E. Mackenzie, M. D.

Oct 23, 1924 (Address) 1306 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-27-24
20-UNDERTAKER, Daniel Easton	ADDRESS 916 Penna Ave

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY

Spec.—8-24-14—M. & T.—2000 Bks.

D 91394

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 001
74 D 91394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Barclay St ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Geraghty

(Residence in Baltimore: No. 1132 Barclay St.; 63 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug. 20, 1861 (Month) (Day) (Year)

7-AGE, 63 yrs. 2 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, William Russell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Marie O'Laughlin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F. Geraghty

(Address) 1132 Barclay St

15- OCT 26 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1 1924, to Oct 25 1924, that I saw h[er] alive on Oct 25 1924, and that death occurred, on the date stated above, at 12[00] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1/4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) William R. Geraghty M. D.

Oct 25, 1924 (Address) 202 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct. 28, 1924

20-UNDERTAKER Elmer W. Conklin ADDRESS 924 E. Eager St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91395

CERTIFICATE OF DEATH.

D 91395

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 E. Preston ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Virginia Moore

(a) RESIDENCE. No. 1719 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced
(or) Wife of Theodore A. Moore

6 DATE OF BIRTH (month, day, and year) Feb 5 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John J. Bregel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Loeffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Husband
(Address) 1719 E. Preston St

15 OCT 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Oct 24, 1924, that I last saw h alive on Oct 23, 1924, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Avery, M. D.

, 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 27 1924
20 UNDERTAKER	ADDRESS 1903
Henry Lutz	7 Broadway

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91396

CERTIFICATE OF DEATH.

21 D 91396

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3505 Mt Pleasant Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meisenhalder

(a) Residence No. 3505 Mt Pleasant Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Meisenhalder

6-DATE OF BIRTH (month, day and year) May 5, 1875

7-AGE. 49 yrs. 5 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael Keppel

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Pauline Burkhardt

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

11- (Informant) Henry Meisenhalder

(Address) 3505 Mt Pleasant Ave

13- Filed OCT 26 1924 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. 65

16-DATE OF DEATH (month, day and year) Oct 23/24

17- I HEREBY CERTIFY, That I attended deceased from 4-21- 1924 to 10-23-1924 that I last saw h[illegible] alive on 10-23- 1924 and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Herrmann M. D.

Oct 26 1924 (Address) 1913 E. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Evangelical Cem. DATE OF BURIAL, Oct 26, 1924

20-UNDERTAKER, L. Sander Sons ADDRESS 1210 Read St

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91397 ✓

CERTIFICATE OF DEATH.

D 91397

31

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2605 Dulaney ST., 20 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Rost.

(a) RESIDENCE NO. 2605 Dulaney ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3rd 1897

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
26	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Nelson Manufacturing
(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Bolto. Md.

PARENTS

10 NAME OF FATHER Henry J. Rost.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Pauline Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Pauline Rost.
(Address) 2605 Dulaney St.

15 OCT 26 1924 ROBERT M. KRAFTER,
Filed ....., 19.... Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1924, to Oct 24, 1924, that I last saw h.. alive on Oct 24, 1924, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis
(Mitral insufficiency)

(duration) Unknown

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Nitch M. D.

10/26, 1924 (Address) 2101 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER F. B. Wippert — ADDRESS 1850 N. Bulto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1474-001 D 91398

1-PLACE OF DEATH Hospital for the Women of Maryland

Registered No.....

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lee Chamberlaine

(a) Residence No. Ruxton, Maryland St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Henry Chamberlaine

6-DATE OF BIRTH (month, day and year) Oct 13, 1877

7-AGE, 47 yrs. ..... mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Berryville, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Carey Garrett

11-BIRTHPLACE OF FATHER (city or town) Wilmington, (State or Country), Del

12-MAIDEN NAME OF MOTHER, Margaret Rizer Lee

13-BIRTHPLACE OF MOTHER (city or town) Martinsburg, (State or Country), West Va

14- (Informant) Mrs Lewis Garrett Carey

(Address) 15 Ruxley Road, Gilford, City

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to Oct 25, 1924, that I last saw h.r alive on Oct 25, 1924, and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam, Blood Chem, Lumbar puncture

(Signed) J. Clyde Warfield, Jr., M. D.

, 19 (Address) Woman's Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Berryville Va — DATE OF BURIAL, Oct 27th 1924

20-UNDERTAKER Henry H Jenkins Sons — ADDRESS Broadway & Fleet St

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21—E.B.R.S.—400 Eks.

D 91399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91399

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 N Rose St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Charles Dillon Jr.

(a) Residence No.... 410 N Rose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) Oct 23/1924

7-AGE. ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas Dillon Jr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Winchester Md

12-MAIDEN NAME OF MOTHER, Hannah Layh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Chas Dillon
(Address) 410 N Rose St

15-
Filed ....., 19.. ROBERT R. KOHLER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 25/1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924 to Oct 25, 1924

that I last saw him alive on Oct 25, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Strangulation Fetich Cord around neck, Bodily Compressed Head

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Unnamed lung and Liver Labor

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. H. Schleuter M. D.

(Address) 330 E Baltimore St

10/25, 1924

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cem

DATE OF BURIAL, Oct 26, 1924

20-UNDERTAKER. John Meerick

ADDRESS 2008 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 91400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91400

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Sloford ST., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura S Wolf

(a) RESIDENCE NO. 3002 Sloford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25. 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hamstead

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant John Wolf
(Address) 3002 Sloford Ave

15 Filed OCT 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 24, 1924, that I last saw h[illegible] alive on Oct 24, 1924 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Acid Dyspepsia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. W. Jones, M. D.

(Address) 22 E Ave 10-25-24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. — DATE OF BURIAL Oct 26, 1924

20 UNDERTAKER Chas. W. Dill. — ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91401

CERTIFICATE OF DEATH.

D 91401

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 Spring Hill Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eva Emig

(a) Residence No. 2900 Spring Hill Ave. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Emig

6-DATE OF BIRTH (month, day and year) Jan. 31, 1873

7-AGE.	If LESS than 1 day.
51 yrs. 8 mos. 23 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Joseph J. Weinkam

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Caroline Zulauf

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Maryland

14- (Informant) Myrtle May Rohrbaugh

(Address) 4503 Kathland Avenue

15- OCT 26 1924 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 24/24

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Oct 24, 1924, that I last saw h[illegible] alive on Oct 23, 1924, and that death occurred, on the date stated above, at 3 40a m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans - duodenal ulcer

Pyelonephritis, suppurative about 4 mo.

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic coma - [illegible]

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter Tublitt M. D.

Oct 25 /24 (Address) 2220 Harlem Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	10/27/24 19

20-UNDERTAKER.	ADDRESS
Henry W. Mears and Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91402

CERTIFICATE OF DEATH.

188-003 D 91402

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Carrollton Av. St. 16 WARD)

2-FULL NAME Otto C. Nordhoff

(a) RESIDENCE No. 616 N. Carrollton Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elise Ottilie Nordhoff

6 DATE OF BIRTH (month, day, and year) Feb 15 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER G. Christian Nordhoff

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Doerry

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant E. Ottilie Nordhoff
(Address) 616 N. Carrollton Ave

15 Filed OCT 26 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fracture of base of skull
J. I. Hg
(durntion) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) automobile accident
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. U. Hennessy, M. D.
(Coroner.)
Oct. 25, 1924 Address 1802 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91403

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. D 91403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 E. Franklin ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Smallwood

(a) RESIDENCE No. 18 E. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B. Smallwood

6 DATE OF BIRTH (month, day, and year) Oct 19 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Seymour

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Brant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs E. L. Burke

(Address) 18 E Franklin St

Filed OCT 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17 1924, to Oct 23rd 1924,

that I last saw h alive on Oct 23rd 1924,

and that death occurred, on the date stated above, at 11:20 m.

The CAUSE OF DEATH* was as follows:

Paralysis. (2nd stroke)

(duration) ..... yrs. ..... mos. 6 ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state name should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 91404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Argyle ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Banton

(a) RESIDENCE. No. 1009 Argyle ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Banton

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic service

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER: Chas. Lofvis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mariah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Grace Williams
(Address) 1009 Argyle Ave

15 Filed OCT 26 1924 19 ROBERT E. KRAUSE Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1924, to Oct. 24, 1924, that I last saw h[illegible] alive on Oct. 23, 1924, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tolppanen M. D.

19 (Address) 1014 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	10/27 1924
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1635 E. Mad. St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 91405

CERTIFICATE OF DEATH.

D 91405
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 W Lombard ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lindsey Mueller

(a) RESIDENCE No 717 W Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 58		7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town) Louisville
(State or country) Ky

PARENTS

10 NAME OF FATHER Ellison Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kentucky

14 Informant Mrs Lindsey Mueller
(Address) 717 W Lombard St

15 OCT 26 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) W R Townsend, M. D.
(Coroner.)

Oct 26, 1924 (Address) 117 N Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

Information should be carefully supplied. Answer all questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91406

CERTIFICATE OF DEATH.

124 D 91406

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholson - Eva M.

(a) RESIDENCE NO. 2232 Ruskin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: B. Frank Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah C. Embrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: James F. Hart

(Address): 1015 Bellona Ave.

Filed OCT 26 1924, 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Oct 25, 1924,

that I last saw h[illegible] alive on Oct 25, 1924,

and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 19-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Wallace Walker M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 27 1924
20 UNDERTAKER: Wm Cook	ADDRESS: 502 E Fayette

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91407

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 91407

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2462 Pine St., 4 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James H Young

(a) Residence No. 2462 N Pine St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Cal

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 26, 1924

7-AGE. ....yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Young

11-BIRTHPLACE OF FATHER (city or town) Raleigh
(State or Country), N C

12-MAIDEN NAME OF MOTHER, Hettie Shed

13-BIRTHPLACE OF MOTHER (city or town) Monroe
(State or Country), N C

14-

(Informant) Thomas Young

(Address) 2462 N Pine St

15-

OCT 26 1924

ROBERT S. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Oct 25, 1924, that I last saw him alive on Oct 24, 1924 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H C Cooper M. D.

, 19 (Address) 723 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 10/28/24, 19....
20-UNDERTAKER. A E Gross	ADDRESS 1900 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91408

90

D 91408 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 605 Bartlett Av. St., 9 WARD)

2-FULL NAME William L. Forestell

(a) RESIDENCE No. 605 Bartlett Av. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Forestell

6 DATE OF BIRTH (month, day, and year) Sept 17 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70.	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 010

(b) General nature of industry, business, or establishment in which employed (or employer) Commerce Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James J Forestell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Agnes Forestell

(Address) 605 Bartlett Ave

15 Filed OCT 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1924, to Oct 22d, 1924,

that I last saw him alive on Oct. 22d, 1924,

and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe M. D.

Oct 24 1924 (Address) 1246 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER E. A. Windsfeld — ADDRESS 501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on bac

E should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA- on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91409

CERTIFICATE OF DEATH.

80 D 91409

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 705 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wheeler

(a) Residence No. 705 Ensor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~ Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 3, 1924

7-AGE, ..yrs. ..mos. 12 ds. If LESS than 1 day, ..hrs. or ..min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto Md
(State or Country).

PARENTS.

10-NAME OF FATHER, Albert Wheeler

11-BIRTHPLACE OF FATHER (city or town) Va
(State or Country).

12-MAIDEN NAME OF MOTHER, Fannie Howard

13-BIRTHPLACE OF MOTHER (city or town) Pen.
(State or Country).

14- (Informant) Albert Wheeler

(Address) 705 Ensor St

15- OCT 27 1924 ROBERT R. KRAUTER, Registrar.
Registrar of Public Health.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 25-24

17- I HEREBY CERTIFY, That I attended deceased from October 13 1924 to October 25 1924 that I last saw him alive on October 24 1924 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Internal Convulsions

(Duration) ..yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Internal Convulsions

to Spasms (Duration) ..yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dreyfus Kennard M. D

10-25. 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Peters cem.	Oct 27 1924
20-UNDERTAKER, no J. B. Jacks	ADDRESS 1332 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 91410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2554 McCulloh ST., 13 WARD)

2-FULL NAME Margaret Jones

(a) RESIDENCE No. 2554 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter C. Jones

6 DATE OF BIRTH (month, day, and year) Oct 16 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John A Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md.

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co. Md.

14 Informant Walter C. Jones (Husband)
(Address) 2554 McCulloh St.

15 Filed OCT 27 1924 Registrar ROBERT P. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1924, to Oct 24, 1924, that I last saw h[illegible] alive on Oct 24, 1924, and that death occurred, on the date stated above, at 11.40 p. m.

The CAUSE OF DEATH* was as follows:

Illeus Pulmonalis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Bernard Harris, M. D.

, 19 (Address) 38 S Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 27 1924
20 UNDERTAKER	ADDRESS
Chas F. Johnson	416 N. Carlin St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91411

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91411

CERTIFICATE OF DEATH.

38

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 Broadway ST., W WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Shirley Kaiser

(a) RESIDENCE NO. 941 N. Broadway ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Herman Kaiser

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mertzel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Herman Kaiser
(Address) 941 N. Broadway

Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1927

17
I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Oct 24, 1927, that I last saw her alive on Oct 25, 1927 and that death occurred, on the date stated above, at 9:30 A m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) ..... yrs. ..... mos 4 ds.
CONTRIBUTORY (Secondary) Congenital Syphilis
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home not
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) Daniel A Dietrich, M. D.
, 19 (Address) 832 S Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAGE ..... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 91412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91412

CERTIFICATE OF DEATH.

34

REGISTERED NO.....

1-PLACE OF DEATH Stafford Hotel

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Mc James

(a) RESIDENCE NO. Stafford Hotel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	55 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md Ellary Land

PARENTS

10 NAME OF FATHER Charles S Hurtgen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Elza C Denneon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Alexander Brown

(Address) Baltimore City Md

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1922 to Oct 24th, 1924.

that I last saw h.r alive on Oct 24th, 1924

and that death occurred, on the date stated above, at 2.30 Am.

The CAUSE OF DEATH* was as follows:

Myocarditis (Coma)

(duration) 5+ yrs. + mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Gordon Wilson, M. D.

, 19 (Address) Grant Preston St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Oct 28 1924

20 UNDERTAKER Henry W Jenkins & Son

ADDRESS Orchard Ave Catons.

Spec.—1-10-21—M&T—1500 Bks.

91413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr Culbertsons 1901 Eutaw Place

113 91413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2643 W. North ST., 15 WARD)

2-FULL NAME Andrew Jackson the 3rd

(a) RESIDENCE NO. 2643 W. North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Jackson Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Regina Pindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Andrew Jackson Jr (Address) 2643 W. North

15 Filed ..... 19 ..... ROBERT P. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/20 1924, to 10/26 1924, that I last saw him alive on Oct 26 1924 and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab + Phys. signs

(Signed) J. B. Culbertsons, M. D.

(Address) 1901 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Oct 28 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91414 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2624 North Calvert St., 17 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Sterling Elden

(a) Residence No. 2624 N Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edward T. Elden

6-DATE OF BIRTH (month, day and year) May 1st 1859 ~~Nov 10, 1854~~

7-AGE 65 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) North Carolina

PARENTS

10-NAME OF FATHER Jonas R Sterling

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Fredericksburg Va.

12-MAIDEN NAME OF MOTHER Caroline Cofer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington D.C

14- (Informant) Florence R Sterling

(Address) 2624 N. Calvert St.

15-

Filed ..... 192.... ROBERT P. KRAMER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1922 to Oct 25- 1924.

that I last saw h.. l.. alive on Oct 25 1924.

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T Watson M. D

Oct 25, 1924 (Address) 2128 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Oct 28, 1924

20-UNDERTAKER. William Cook — ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH stated EXACTLY. AGE should be stated EXACTLY. OCCUPATION should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91415

HEALTH DEPARTMENT—CITY OF BALTIMORE

155 D 91415

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 21

2-FULL NAME St. Clair Street Wild

(a) RESIDENCE NO. 772 St. Peter ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence L. Wild

6 DATE OF BIRTH (month, day, and year) Aug 3, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 906

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Wild

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Priday

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) Wife 772 St Peter St

15 Filed OCT 27 1924 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct - 24, 1924, to Oct 26, 1924, that I last saw h in alive on Oct - 26, 1924, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

Padgets Disease of Bones.
Carcinoma Secondary
Generalized Arteriosclerosis.
(duration) 5? yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Longcope M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Oct 28 24

20 UNDERTAKER W. Cook — ADDRESS 1826 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91416

CERTIFICATE OF DEATH.

D 91416
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Linkney Place ST.: 17 WARD)

2-FULL NAME Francis Peters

(a) RESIDENCE. NO. 401 Linkney Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 21 /24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Peters

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balt. Co.
(State or country)

14 Informant Joseph Peters
(Address) 401 Linkney Place.

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-20, 1924, to 10/25, 1924, that I last saw him alive on 10-25, 1924, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Failure Foramen Ovale to close

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Edward Miller, M. D.

, 19 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery.	Oct. 27 1924

20 UNDERTAKER George F. Ruth ADDRESS 1726 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91417 × 94206 D 91417

CERTIFICATE OF DEATH.

D 91417

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 W 27 ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Gainor

(a) RESIDENCE NO. 400 W 27 ST., WARD Belair Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Gainor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James H Doggett
(Address) 1103 Ruxton Ave

15 Filed OCT 2 1924 ROBERT P. KRAUTZ Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Oct 25, 1924.

that I last saw her alive on Oct 25, 1924,

and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos 9 ds

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) Unknown yrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed E Chenoweth M. D.

Oct 26 1924 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Harford Co. DATE OF BURIAL Oct 27 24

UNDERTAKER CHENOWETH & SON ADDRESS 112 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91418

CERTIFICATE OF DEATH.

101-001 D 91418

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3618 Railroad Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Grady

(a) RESIDENCE NO. 3618 Railroad St., WARD

(Usual place of abode) Orange Co Va

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Grady

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Wheeler

(Address) 1127 W 37 St

15 OCT 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924, to Oct 24 1924, that I last saw him alive on Oct 24, 1924, and that death occurred, on the date stated above, at 1145 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) D Ward M. D.

Oct 27 1924 (Address) 865 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tinderastia Va	Oct 26 1924

20 UNDERTAKER SHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91419

D 91419

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1908 Barclay St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belinda Roberts

(a) Residence No. 1908 Barclay St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Feb. 4, 1846

7-AGE.	If LESS than 1 day,
78 yrs. 8 mos. 19 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Charles Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Catherine Bodensick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant). Mrs. H. N. Roberts

(Address) 1908 Barclay St.

15- Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924 to Oct 23, 1924 that I last saw h[illegible] alive on Oct 23 1924 and that death occurred, on the date stated above, at 1.05P m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation & Heart Renal

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Renal

(Signed) J. Labrobe Ewald M. D.

Oct 27, 1924 (Address) 2945 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem	Oct 27, 1924
20-UNDERTAKER John H. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be carefully answered. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See that it may be properly classified. In plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91420 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 13 ST., 5 WARD) REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis E. Reisner

(a) RESIDENCE NO. 1314 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) April 8-1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis E. Reisner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Gutenko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen Reisner Wife

(Address) 1314 E Lanvale St

15 Filed OCT 27 1924, 19 HUBERT F. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1924

17

I HEREBY CERTIFY, That I attended deceased from October 22, 1924, to October 25, 1924, that I last saw h[illegible] alive on October 24, 1924, and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Acidosis

Myocardial Insufficiency

(duration) ✓ yrs. ✓ mos. 3 (?) ds.

CONTRIBUTORY (Secondary) Acute gastro-enteritis

(duration) ✓ yrs. ✓ mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidor S. Fry M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 27 1924
UNDERTAKER	ADDRESS
Wm Fiaschowski	1611 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 91421

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 Belvidere Ave St.) (2 WARD)

2-FULL NAME Claude Edward Bossom

(a) RESIDENCE No. 136 E. Belvidere Ave St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Dorothea Bossom

6 DATE OF BIRTH (month, day, and year) July 28 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Hengler Creamery Co Balto Co Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Edw. Bossom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie B. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Anna D. Bossom

(Address) 136 E. Belvidere Ave.

15 OCT 27 1924

16 Registrar

HUBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from about Oct. 19 1924 to Oct. 24 1924

that I last saw h alive on Oct. 24 1924

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows: Tuberculosis of lungs

Duration (duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Irvin Edwards, M. D.

(Address) 700 N. Mt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Oct. 28 1924

20 UNDERTAKER Wm J. Eckner Sons ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91422

CERTIFICATE OF DEATH.

D 91422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Smith ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Linwood Taylor

(a) RESIDENCE No. 1210 Smith St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ernest Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sadie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sadie Taylor
(Address) 1210 Seboch St.

15 Filed ....., 192.... Registrar

ROBERT R. KRAUTER,
Registrar Bureau of Vital Statistics

OCT 27 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. gastro enteritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Bronchitis

(duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Oct 25, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER Sam'l E. Chase Son — ADDRESS 1408 Mosher

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91423 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 15 90

City of BALTIMORE: (No. 3307 Egerton Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. H. Ehlen

(a) Residence No. 3307 Egerton Road St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 29, 1848

7-AGE, 76 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry W. Ehlen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Ellen Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Mrs. E. C. Korff

(Address) 3307 Egerton Road

15- OCT 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) OCT 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 7 1924, to Oct 26, 1924, that I last saw him alive on Oct 25 1924, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremic Coma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Emmy, M. D.

OCT 28 1924 (Address) 6 W. Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, Western — DATE OF BURIAL, OCT 28 1924, 19....

20-UNDERTAKER Geo W Little — ADDRESS 2748 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91424

CERTIFICATE OF DEATH.

90 D 91424

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N Ellwood ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kramer

(a) RESIDENCE No. 524 N Ellwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Kramer

6 DATE OF BIRTH (month, day, and year) April 9-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	42	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 837

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christ. Lauterbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Burk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew Kramer

(Address) 529 N Ellwood St

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to October 24, 1924, that I last saw h[illegible] alive on October 22, 1924 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

Myocardial Insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Boyd, M. D.

, 19 (Address) 54 N. Mellon Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct. 28 1924
20 UNDERTAKER	ADDRESS
Mrs. L. Miller & Son	2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91425

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick August Goetzke

(a) RESIDENCE NO. 1000 N. Patterson Park ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mamie Goetzke

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Repair Man

(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Co.

(c) Name of employer C & P Tel. Co. 086

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Goetzke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Frederick Goetzke (Address)

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to October 23, 1924, that I last saw him alive on October 23, 1924, and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Streptococcus viridans).

(duration) 0 yrs. 0 mos 28 ds.

CONTRIBUTORY (Secondary) Dental caries.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood Culture.

(Signed) A. Austin Pearre, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 27 1924

20 UNDERTAKER Jno. C. Miller & Son ADDRESS 2338 Jefferson

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91426

CERTIFICATE OF DEATH.

100-001

D 91426

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2638 Harlem Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Pfotzer

(a) Residence No. 2638 Harlem Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Pfotzer

6-DATE OF BIRTH (month, day and year) Dec. 5 1866

7-AGE. 57 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Cambridge Md.

PARENTS.

10-NAME OF FATHER, John H. Sapp

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cambridge Md

12-MAIDEN NAME OF MOTHER, E Jane

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Henry J. Pfotzer

(Address) 2638 Harlem Ave

15- Filed OCT 27 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 25/24

17- I HEREBY CERTIFY, That I attended deceased from Feb - 1924 to Oct 24 - 1924

that I last saw h.... alive on Oct - 24 1924

and that death occurred, on the date stated above, at 12 AM

The CAUSE OF DEATH* was as follows:

Mental - Uterio - Valvular disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchs - Pneumonia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C Bonner, M. D

19 (Address) 125 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem

DATE OF BURIAL. Oct 27, 1924

20-UNDERTAKER, Philip Herwig

ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91427

CERTIFICATE OF DEATH.

D 91427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Shields Place ST., 1 WARD)

2-FULL NAME Irene Leggroes

(a) RESIDENCE NO. 912 Shields Place ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANY ERASURE OR ALTERATION will render certificate void. All information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Daisy Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daisy Dorsey
(Address) 912 Shields Place

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Oct. 29, 1924 (Address) 2812 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER S. Mack R. Gilliat — ADDRESS 1225 Eastern

Spec.—1-10-21—M&T—1500 Bks.

D 91428

D 91428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Roth

(a) RESIDENCE NO. 131 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Roth.

6 DATE OF BIRTH (month, day, and year) Dec. 28-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	24	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Adam Roth

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) md.

12 MAIDEN NAME OF MOTHER Pauline Libutzki

13 BIRTHPLACE OF MOTHER (city or town) Ger (State or country)

14 Informant Mary Roth.

(Address) 131 S. Clinton St

Filed OCT 27 1924 HUBERT R. KRAUTER, Registrar

Central Record Clerk Hann

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924 to Oct 25, 1924.

that I last saw him alive on Oct 25, 1924

and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Septic sore throat

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Edema of larynx

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 25

Was there an autopsy? No Tracheotomy

What test confirmed diagnosis? —

(Signed) B Macgowan, M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Oct 29 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91429

188-006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

2-FULL NAME Philip H White

(a) RESIDENCE NO 2718 Brooks st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Stewart Dust Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Leahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E White
(Address) 2718 Brooks

15 Filed OCT 2 1924 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk Hann

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull -

a few hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell from Wagon
(duration) yrs. mos. ds.

(Signed) W K Jamison, M. D.
(Coroner.)

10-26, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 28 1924
20 UNDERTAKER Lilly + Zeiler	ADDRESS 403 S Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificate. TION is very important See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91430

CERTIFICATE OF DEATH.

90 D 91430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Monroe ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milburn Soper.

(a) RESIDENCE. NO. 203 N. Monroe. ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Soper.

6 DATE OF BIRTH (month, day, and year) Sept 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60 yr.	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Water Dept

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Ellicott City
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Soper

11 BIRTHPLACE OF FATHER (city or town) Maryland.
(State or country)

12 MAIDEN NAME OF MOTHER Melissa Jones

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Annie M. Soper
(Address) 203 N Monroe.

15 Filed OCT 27 1924 19 ROBERT S. KRAUTH Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/24 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1924, to Oct 25, 1924, that I last saw him alive on Oct 25, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectaris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Organic Heart

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John Hovell, M. D.

, 19 (Address) 1443 W. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 28 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91431

CERTIFICATE OF DEATH.

NW-001 D 91431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Howard Place) 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Miller

(a) RESIDENCE. No. 2708 Howard Place. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Martha Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Alton L. Miller
(Address) 2708 Howard Place

15 Filed OCT 27 1924 ROBERT R. KRAUSER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1924, to Oct. 27, 1924, that I last saw her alive on Oct. 26th, 1924, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Endarteritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage (Rt. Internal Capsule) (duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

10/27/1924 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mauch Chunk Pa.	Oct 28 1924
20 UNDERTAKER George J. Smith	ADDRESS 153 L Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91432
Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No. 2425 Linden Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kopel Hyman

(a) Residence No. 2425 Linden Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year)

7-AGE. 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Novelties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Benj Hyman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Ida Lichtenstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-
(Informant) B. H. Hyman
(Address) 2425 Linden Ave

OCT 27 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 26/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923 to Oct 26, 1924 that I last saw him alive on Oct 25, 1924 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension, Cbo.,
Interstitial Nephritis,
Uremia, Cerebral Hemorrhage
(Duration) 1 About 1 year yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. H. Morrison, M. D.
, 19 (Address) 1013 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Southern — DATE OF BURIAL. 10/27/1924

20-UNDERTAKER. Sol Gunsan & Bro — ADDRESS 1124 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91433

CERTIFICATE OF DEATH.

100-801 ✓ D 91433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Parrish ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Evans

(a) RESIDENCE No. 911 Parrish ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/30/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER [redacted] A. Evans

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Virgie Evans

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Virgie Evans
(Address) 911 Parrish St.

15 OCT 27 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/1924

17 I HEREBY CERTIFY, That I attended deceased from 10/24/, 19 24, to 10/25/, 19 24, that I last saw her alive on 10/25/, 19 24, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
(Primary)

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Hayes Kerr, M. D.

Oct 27, 1924 (Address) 912 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Oct 27 1924

20 UNDERTAKER John F Owens — ADDRESS 538 Dulaney

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91434

CERTIFICATE OF DEATH.

1187-007

REGISTERED NO. D 91434

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 1 WARD)

2-FULL NAME Joseph Studzinski

(a) RESIDENCE No 907 S. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Ship Building
(c) Name of employer Balto Copper Works

9 BIRTHPLACE (city or town) (State or country) Butte

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rosa Studzinsky
(Address) 907 S. Potomac St

OCT 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Asphyxia accidental while operating a saw - piece of wood struck (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) A. Whiley, M. D.
(Coroner.)
Oct. 25, 192 4 (Address) 1637 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. State ... yrs., 1/2 mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct 28 1924
20 UNDERTAKER	ADDRESS
Stephen J. Fiackowski	1000 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Swigowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

91435 709
175

CERTIFICATE OF DEATH.

10

D 91435

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED No.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Snow (Swigowski)

(a) RESIDENCE No. 914 S. Belnord St., Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer ..... —

9 BIRTHPLACE (city or town) (State or country) ..... Maryland

PARENTS

10 NAME OF FATHER Edward Snow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Matanowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924, to Oct 26, 1924, that I last saw h.. alive on Oct 26, 1924, and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Gangrenous stomatitis

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Diphtheria (nasal + pharyngeal) Impetigo contagiosa (buccal) — 7 days

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Harper, M. D.

10/26/1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 27 1924

20 UNDERTAKER Teplen & Frankowski ADDRESS 1838 E. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181 D 91436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N. Central Ave ST., 10 WARD)

2-FULL NAME John Roessinger

(a) RESIDENCE NO 807 N. Central Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Roessinger

6 DATE OF BIRTH (month, day, and year) Jan 18/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 88
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Roessinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Roessinger ($on)
(Address) 1636 N. Bond St

15 OCT 2 71924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Probably Oct 24 or 25/24 ~~Oct 25/24~~

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixiation
(Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Howe, M. D.
(Coroner.)
10/27/24, 192 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Oct 28 1924
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 91437

HEALTH DEPARTMENT—CITY OF BALTIMORE

001 ✓

D 91437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Pennsylvania ave ST., 14 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fretus Birkis

(a) RESIDENCE NO. 1401 Pennsylvania av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Louis Birkis

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca E. Reese

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14

Informant

(Address)

15 Filed OCT 27 1924, 19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924, to Oct 27th, 1924,

that I last saw h~~e~~ alive on , 19 ,

and that death occurred, on the date stated above, at 4.05 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ed Krampf, M. D.

Oct 27, 1924 (Address) 1709 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER City Director Health.

ADDRESS

OCT 27 1924

OCT 27 1924

1804 Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91438

10-001

D 91438

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 17 WARD)

2-FULL NAME Leon Mantrey

(a) RESIDENCE NO. 1006 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

OCT 27 1924

(1806)

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 19 24 to 10-23, 19 24

that I last saw him alive on 10-23, 19 24

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Clin.

(Signed) Claude A. Dorsey, M. D.

10-25 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health

ADDRESS

Per Wm. F. WOOBAL

OCT 27 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 91439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. Penitentiary

CITY OF BALTIMORE: (No. 954 Forrest St. 10 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ross

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Un yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Un

about 51	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Un

PARENTS

10 NAME OF FATHER Un

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un

12 MAIDEN NAME OF MOTHER Un

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un

14 Informant (Address) U. S. Penitentiary, Warden, Pen.

15 Filed Robert T. Morrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 19. 1923 to Oct 18, 1924, that I last saw him alive on Oct. 18, 1924, and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cardiac insufficiency

Chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory tests

(Signed) John M. Edmonds, M. D.

, 19 (Address) 95 Forrest St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Dept. of Health, OCT 27 192

Per W. E. Woodall

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

CT 2 71924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91440

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 N. Wolfe St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frech

(a) Residence No. 935 N Wolfe St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 25 1924

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, — hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto

PARENTS.

10-NAME OF FATHER. John Frech

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Mamie Bousek

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Balto

14- (Informant) John Frech

(Address) 935 N Wolfe St

15- Oct 27 1924 Robert P. Harrison Registrar.

CT2 71924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 26/24

17- I HEREBY CERTIFY, That I attended deceased from 6-25 19 24 to Oct 26 19 24 that I last saw h[illegible] alive on Oct 25 19 24 and that death occurred on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Chorea

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity Birth

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gerdine

(Signed) Fred Lincke M. D.

(Address) 800 N Wolfe St

Oct 26 1924

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Oct 27 1924

20-UNDERTAKER. Jno F Eversfield & Son — ADDRESS 1906 Eastland Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91441

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D 91441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 941 N. Milton St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Ladbay

(a) Residence No. 741 N. Milton St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), ...

PARENTS.

10-NAME OF FATHER, John J. Bradley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Emma Payonek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) Emma Bradley

(Address) 741 N. Milton Ave

15- Filed OCT 27 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 ....., 19 24, to Oct 25 ....., 19 24,

that I last saw h.....alive on ....., 19.....,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D

....., 19 . (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL, Oct 29, 1924

20-UNDERTAKER Paul E. Brady ADDRESS 1906 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91442

D 91442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.) 27 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Wells.

(a) RESIDENCE No. 5242 Park Heights Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1872

7 AGE: Years 52; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Medical practitioner

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Carroll County, Md.

PARENTS

10 NAME OF FATHER: Dr. Richard C. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER: Ann Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Walter I. Wells

(Address): 4912 Park Heights Ave.

OCT 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24. 1924. to Oct 25. 1924.

that I last saw him alive on Oct. 25. 1924

and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. 3 hrs.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes. Date of Oct. 25.

Was there an autopsy? no.

What test confirmed diagnosis? X ray. operation.

(Signed) M Edwards. M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery.

DATE OF BURIAL: 10/28 1924

20 UNDERTAKER: Henry H. Mears & Son

ADDRESS: 805 N. Calvert

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91443

CERTIFICATE OF DEATH.

16 D 91443

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S Wolf ST., V WARD)

2-FULL NAME Eva Yeager

(a) RESIDENCE No 711 S. Wolf ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26/24

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Alfred Yeager

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Banaszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Alfred Yeager
(Address) 711 S Wolf St

15 Filed ..... Robert P. Harrison, Registrar

OCT 27 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Robert Compression Brain, due Fracture of Skull around neck during delivery (duration) ..... yrs. ..... mos. 1½ ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James Ligenfelter, M. D.
(Coroner)

Oct 27, 1924 (Address) 706 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, — DATE OF BURIAL Oct 28. 1924.

20 UNDERTAKER W. F. Sadowski. — ADDRESS 705 S Ann St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91444 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91444

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1417 Riverside ave St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Von Hagle

(a) Residence No. 1417 Riverside ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of widow late of Geo. Von Hagle

6-DATE OF BIRTH (month, day and year) March 3. 1841

7-AGE, 83 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, John Sine

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Can't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Thos. Morse

(Address) 1417 Riverside ave

15- Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 25. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924 to Oct 25, 1924, that I last saw h alive on Oct 24, 1924 and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH was as follows:

Senile Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1027 1924 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Oct 28, 1924

20-UNDERTAKER, Margaret L. Feyne ADDRESS 1712 Light St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT2 71924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.) (WARD)

REGISTERED NO. 001 1922 D 91445

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E. Fitzgerald

(a) RESIDENCE NO. 1420 E. Fort Ave. ST., WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred About 70 yrs. mos. ds. How long in U. S., If of foreign birth? About 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Fitzgerald

6 DATE OF BIRTH (month, day, and year) Jan 28 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Fitzgerald 1420 E. Fort Ave

15

16 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/24

17

I HEREBY CERTIFY, That I attended deceased from 9/1/24, 19.., to 10/26/24, 19.., that I last saw him alive on 10/26/24, 19.., and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH was as follows:

Arterio Sclerosis

Hypertension (duration) Pneumonia yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 10/25/24

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) H. W. Kelly, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 27 1924
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1111 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 27 1924

Spec.—1-10-21—M&T—1500 Bks.

D 91446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+45 D 91446

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary C. Canon

(a) RESIDENCE NO. 526 Franklin St (Usual place of abode) Johnstown Pa ST., WARD

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Johnstown, Pa.

PARENTS

10 NAME OF FATHER S. Dean Canon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ebensburgh Pa.

12 MAIDEN NAME OF MOTHER Mary E. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Blairsville Pa.

14 Informant (Address): Mrs A. McMullen Johnstown Pa

15 OCT 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1922, to Oct 27, 1924, that I last saw her alive on Oct 27, 1924, and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma rectum.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Dec 12'22

Was there an autopsy? No

What test confirmed diagnosis? Pathological exam

(Signed) Grant Ewart, M. D.

. 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnstown. Pa	Oct 27 1924

20 UNDERTAKER: Lowbook

ADDRESS: 502 E Market

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91447 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2108 N Charles St., 17 Ward) Registered No. 89

2-FULL NAME Susie Sultzer Jenness

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2108 N Charles St. St., Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? 72 yrs. 5 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. C. Jenness

6-DATE OF BIRTH (month, day and year) Apr-30-1852

7-AGE 72 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS

10-NAME OF FATHER, Capt Phillips

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14-

(Informant) Miss Sadie Rudolph

(Address) 2011-N-Calvert St

15-

Filed OCT 27 1924, 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 26/24

17- I HEREBY CERTIFY, That I attended deceased from April, 19 23, to Oct. 26, 19 24, that I last saw h.. alive on ... 25, 19 24, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Arteri-Sclerosis with Angina Pectoris

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 day

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

Oct. 27, 1924 (Address) 2514 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery — DATE OF BURIAL, Oct 28/ 1924

20-UNDERTAKER STEWART & HOWETT COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Burial Permit Clerk

TYPE OR WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS a
in plain terms, so that it may be properly classified. Exact statement of OCCUP.
instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91448

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 Kate Ave ~~or~~, 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred ~~Brown~~ Matthews

(a) RESIDENCE NO. 2626 Kate Ave. ST., WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred ~~Life~~ 49 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? 49 yrs. 4 mos. 11 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Margaret Matthews

6 DATE OF BIRTH (month, day, and year) June 14, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	49	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendant

(b) General nature of industry, business, or establishment in which employed (or employer) 986

(c) Name of employer Empire Laundry.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John W.m Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa.

12 MAIDEN NAME OF MOTHER Annette L. Hetzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John G. Matthews (Address) 8 E. Franklin St.

Robert P. Harrison, Registrar

Burial Permit Clerk

CT 2 71924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. , 1923, to Oct. 25 , 1924 .

that I last saw him alive on Oct. 25 , 1924 ,

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Complete heart-block with Stokes-Adams syndrome.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) Abbeyman, M. D.

10-25-1924 (Address) 1012 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 28 1924
20 UNDERTAKER	ADDRESS
Stewart & Co.	108 N. Kirk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91449

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mashy Alpert

(a) RESIDENCE No. 2350 Eutaw Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 80 — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Solomon Perlman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Dr Nathan Alpert

(Address) 2350 Eutaw Place

15 Filed Oct 27 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

CT2 71564

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Oct 27, 1924, that I last saw her alive on Oct 27, 1924, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Manninger M. D.

Oct. 27 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Sterling Pun — DATE OF BURIAL: Oct 28 1924

20 UNDERTAKER: Sol Leinow & Bro — ADDRESS 1127 E. Balto st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D 91450

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Edmondson ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Cecilia Reilly

(Residence in Baltimore: No. 3004 Edmondson St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH: May (Month) 2 (Day) 1863 (Year)

7-AGE: 61 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE (State or country): Parma

PARENTS

10-NAME OF FATHER: Martin Gilboy

11-BIRTHPLACE OF FATHER (State or country): Parland

12-MAIDEN NAME OF MOTHER: Sarah Jordan

13-BIRTHPLACE OF MOTHER (State or country): Parland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Reilly

(Address) 3004 Edmondson

15- OCT 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 24 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to, Oct 24 1924, that I saw h.. alive on Oct 24th 1924 and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Myocarditis

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Acute Cardiac dilatation

(Duration) yrs. mos. 3 ds.

(Signed) Frank T. Hillis M. D.

Oct 27th, 1924 [Address] 2838 Edmondson

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Oct 28, 1924

20-UNDERTAKER: E J Ramm & Son — ADDRESS: 1938 E Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1716 N. Bond St., 8 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mathilda Bode

(a) Residence No. 1716 N. Bond St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan. 15, 1849

7-AGE. 75 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Bode

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Emma Plumhoff

(Address) 1716 N. Bond St

15- OCT 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 26/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 to Oct 26 19 24 that I last saw h... alive on Oct 26 19 24 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Chronic Arthritis deformans & Valvular Heart disease

Interval, 29 (Duration) yrs. mos. ds.

Infirmity of Age

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed H. A. Meyer M. D.

10/27, 1924 (Address) 1031 N. Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Oct 28, 1924

20-UNDERTAKER. H. Sander Sons ADDRESS 1710 Mad St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91452

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 D 91452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Brooks

(a) RESIDENCE No. 1732 a Carlyle Pl ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Maryland
(State or country)

PARENTS

10 NAME OF FATHER Richard Brooks

11 BIRTHPLACE OF FATHER (city or town) ..... Va.
(State or country)

12 MAIDEN NAME OF MOTHER Blanche Jones

13 BIRTHPLACE OF MOTHER (city or town) ..... Va.
(State or country)

14 Informant ..... Rectal
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27- 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Oct 27, 1924, that I last saw her alive on Oct 27 -, 1924, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Influenza meningitis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/22/24

Was there an autopsy? Yes

What test confirmed diagnosis? Organism cultured.

(Signed) Edmund H Kerper, M. D.

10/22, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Oct 28 1924

UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H D 91453

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital WARD)

2-FULL NAME William Hayes

(a) RESIDENCE NO. 1159 Calhoun St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot black

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

086

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Miss Hayes

(Address) 640 Motor st.

15 Filed OCT 28 1924 Registrar ROBERT R. KRAUTER Social Service Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 1924, to 10-25, 1925, that I last saw h alive on 10-25, 1925, and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septicemia (strept)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) A C Monninger, M. D.

Oct 25 1924 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cty.	OCT 28 1924
20 UNDERTAKER A Adolphus Hasted Md.	ADDRESS 159 Hunter ave. Catonsville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17-5-26

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91454

CERTIFICATE OF DEATH.

X 127 D 91454

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Blades

(a) RESIDENCE No. 1306 N. Mulberry ST. WARD St Michaels
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy A. Blades

6 DATE OF BIRTH (month, day, and year) July 27, 1877

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
47	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 0/5

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Blades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 28 1924 WILLIAM A. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 1924 to Oct 27 1924, that I last saw him alive on Oct 27 1924, and that death occurred, on the date stated above, at 6 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Obstruction of portal vein
Myocardial failure

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
Hemorrhage oesophagus (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of Oct 18

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Thos Harrell M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michaels. Md — DATE OF BURIAL Oct 28 1924

20 UNDERTAKER Wm Cook — ADDRESS 5028 Pitts Ave

N. B.—WHITE PENCIL, WITH CONSIDERABLE PRESSURE, SHOULD BE USED. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91455 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 Lyman Ave. St., 21 Ward) Registered No. 90

2-FULL NAME. Dorothy L. Newton

(a) Residence No. 404 Lyman Ave St., Ward.
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) Dec 30-1901

7-AGE. 22 yrs. 9 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. invalid

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. George Newton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. May E. Downes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Geo W. Newton

(Address) 404 Lyman ave

15- Filed OCT 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 27-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924 to Oct 26, 1924 that I last saw h[er] alive on Oct 25 1924 and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Mitral & Aortic

Dropsy - Mitral Stenosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

Oct 28, 1924 (Address) 501 Sheridan ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cem. DATE OF BURIAL. Oct. 29 1924

20-UNDERTAKER. John O. Whitehill ADDRESS [illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91456

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1423 Edmondson Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Effie Hargrave

(a) Residence No. 1423 Edm St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis E Hobbs

6-DATE OF BIRTH (month, day and year) July 9. 1839

7-AGE, 85 yrs. 3 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va.
(State or Country),

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town)..... "
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Kirby

13-BIRTHPLACE OF MOTHER (city or town)..... Va
(State or Country),

14-

(Informant) Maud L. Hargrave

(Address) 1423 Edmondson ave

15-

Filed OCT 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 27. 24

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to Oct 27 1924

that I last saw him alive on Oct. 26 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Epithelioma, R Ham & Jaw
Malignant + Hemorrhage
osteomalacia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

Senility (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Kraus M. D.

10/28, 1924 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va — DATE OF BURIAL, Oct 28., 1924

20-UNDERTAKER, John A Mitchell — ADDRESS 1121 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91457

CERTIFICATE OF DEATH.

31 D 91457

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 801 Rutland Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Nanie Bunch

(a) Residence No..... 801 Rutland Ave St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced [redacted]D of (or) WIFE of Archie Bunch.

6-DATE OF BIRTH (month, day and year) uncertain

7-AGE, 30 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Work

(b) General nature of industry, business, or establishment in which employed (or employer)..... 610

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... S.C.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm. Briggs

11-BIRTHPLACE OF FATHER (city or town)..... S.C.
(State or Country),

12-MAIDEN NAME OF MOTHER, Ida Dixon

13-BIRTHPLACE OF MOTHER (city or town)..... S.C.
(State or Country),

14- (Informant)..... Alexander Briggs

(Address)..... 1801 Erlewood St

15- Filed ..... 1924 ROBERT R. KRAUTH Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 25/1924

17- I HEREBY CERTIFY, That I attended deceased from August, 1924 to Oct. 25, 1924

that I last saw her alive on Oct 24, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

uncertain
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Laryngeal T.B.C.

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

, 19 (Address) 1429 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Smith Field va — DATE OF BURIAL, Oct 28, 1924

20-UNDERTAKER, Edward Bryson — ADDRESS 631 Orleans St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91458

CERTIFICATE OF DEATH.

129 D 91458

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2147 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alice Johnson

(a) RESIDENCE. NO. 2147 Division ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Johnson Deceased

6 DATE OF BIRTH (month, day, and year) Aug 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Mrs. Calvert Apts.

9 BIRTHPLACE (city or town) (State or country) Essex Co - Va

PARENTS

10 NAME OF FATHER Albert Johnson

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) Essex Co (State or country) Va.

14 Informant Mrs Mozie Porter
(Address) 2141 Division St

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

OCT 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to Oct 25, 1924, that I last saw h[illegible] alive on Oct 25, 1924, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H. Dright, M. D.

Oct 27, 1924 (Address) 209 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct 28 1924

20 UNDERTAKER: Samuel T. Hinsley — ADDRESS: 1138 N Eddle

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91459

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ D 91459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital 16 Registered No.....

City of BALTIMORE: (No..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis E. Williams

(a) Residence No. 1104 N. Carey St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~Married~~ Betty Williams

6-DATE OF BIRTH (month, day and year) 1868.

7-AGE. 56 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do. Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do. Do.

14- (Informant) Bay View Hospital

(Address) Balto., Md.

15- Filed OCT 28 1924 HUBERT F. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/26/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1923 to Oct. 26, 1924

that I last saw him alive on Oct. 26, 1924

and that death occurred, on the date stated above, at 11.15 A.M.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What lest confirmed diagnosis? Clinical & Serological

(Signed) W. H. Hamill M. D.

10/27/, 1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Loudon Park	Oct 30
20-UNDERTAKER	ADDRESS 578
Samuel Wesley Riddle	

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91460

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Division St. ST. 14 WARD)

2-FULL NAME Margaret E. Waters

(a) RESIDENCE. No. 2419 Division St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Waters

6 DATE OF BIRTH (month, day, and year) 12-3-'64

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clarence Thomas (nephew)

(Address) 2119 Division St

15 Filed OCT 28 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27- 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1924, to Oct. 27, 1924, that I last saw h[illegible] alive on Oct. 26, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

from History about 6 mos

Personal Knowledge (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No.

What test confirmed diagnosis? ~

(Signed) George C. Paige, M. D.

(Address) 1 Mon. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn	Oct 28 1924
20 UNDERTAKER	ADDRESS
Daniel J. Kennedy	1 Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-15-21—M&T—1500 Bks.

Harris

D 91461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135D 91461

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Harris

(a) RESIDENCE NO. 30 Harrison Street ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of, (or) WIFE of Yetta Harris

6 DATE OF BIRTH (month, day, and year) Sept 15 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Indse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1737 E Baltimore St

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 27, 1924

that I last saw h. alive on Oct 27, 1924

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Benign hypertrophy prostate (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Oct 15, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Philip Jacobson, M. D.

, 19 (Address) Mercy Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	10/28 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1737 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91462

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew Cemetery St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eli Kadensky

(a) Residence No. 1426 E. Fayette Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Kadensky

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(informant) Jack Lewis

(Address) 1439 E. Balt St

OCT 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-27-24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4th, 1924 to Oct. 26th 1924

that I last saw him alive on " " " 1924

and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Same

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. L. Wiesman M. D.

10 28, 1924 (Address) 30 S. B'way

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL. 10/28, 1924

20-UNDERTAKER. Jack Lewis 1439

ADDRESS E Balt St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 91463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Arlington Ave ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Grant

(a) RESIDENCE NO. 223 N. Arlington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Grant

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cement Finisher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West India

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Emma Grant
(Address) 223 N. Arlington Ave.

15 Filed OCT 28 1924 By ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken Neck at once accidentally fall down stairs steps

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Norton, M. D. (Coroner.)

Oct 25 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct. 29 1924
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Schrader St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91464

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 D 91464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 S Munford ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Urbanska

(a) RESIDENCE NO 736 S. Munford ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 10 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress 069
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rosenfeld Co

9 BIRTHPLACE (city or town) Jaltocity
(State or country)

PARENTS

10 NAME OF FATHER Stanislaus Urbanska

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Pawlak

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mary Biedaonska
(Address) 736 S Munford

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Post Operative Cardiac Failure following removal of Thyroid

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenton, M. D.
(Coroner.)

Oct 27, 1924 (Address) 708 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Oct 30, 1924.

20 UNDERTAKER W F Sadowski ADDRESS 905 S. Ann.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91465 — 162 — D 91465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 6 E. Cumberland St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas—

(a) Residence No. 6 E. Cumberland St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male—

4-COLOR OR RACE, Negro—

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/26/24

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER, William Thomas—

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or Country),

12-MAIDEN NAME OF MOTHER, Lillie Dobson

13-BIRTHPLACE OF MOTHER (city or town) Richmond Va (State or Country).

14- (Informant)
(Address)

15- OCT 28 1924 192.... Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/26/24

17- I HEREBY CERTIFY, That I attended deceased from 10-26 1924 to 10-26 1924

that I last saw h. alive on 10-26 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Inter-ventricular asphyxia —

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pale, premature

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Bausang M. D

10-26-1924 (Address) 1202 Westwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: OCT 27 1924

20-UNDERTAKER, Baltimore Health Dept. — ADDRESS

per Wm. E. Woodall

Filed. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91466

CERTIFICATE OF DEATH.

3 M D 91466

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. 4 ST., WARD)

Municipal Tuberculosis Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raleigh Walker

(a) RESIDENCE No. 124 Pearl st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1917, to Oct. 27, 1924, that I last saw him alive on Oct. 27, 1924, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. Duthie, M. D.

10-27-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 28 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Peel Hays.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91467

CERTIFICATE OF DEATH.

38 D 91467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME Peel Hays

(a) RESIDENCE NO 2101 Hargrove Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) W. Virginia
(State or country)

PARENTS

10 NAME OF FATHER Bob Hays

11 BIRTHPLACE OF FATHER (city or town) W. Va
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) W. Va
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 192X

17

I HEREBY CERTIFY, That I attended deceased from 6-17 .192X to 10-26 .192X,

that I last saw him alive on 10-26 .192X

and that death occurred, on the date stated above, at 9:15 a m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Insufficiency; Myocardial Insufficiency

(duration) yrs. 6 mos. Weeks ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + autopsy

(Signed) Claude C. Drane, M. D.

10-26 192X (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 28 1924
20 UNDERTAKER	ADDRESS
Sam'l M. Chase & Son	1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

Gardner

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓ D 91468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 91468

REGISTERED NO.....

CITY OF BALTIMORE: (No. 831 Clifford St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gardner

(a) RESIDENCE NO. 831 Clifford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years ~~Months~~ Days ~~10~~ 25 1 If LESS than 1 day 16 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Alfred Morris

11 BIRTHPLACE OF FATHER (city or town) ~~Balto~~
(State or country) Md

12 MAIDEN NAME OF MOTHER Edna Gardner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Bell Investigations

(Address) 831 Clifford St.

Filed OCT 28 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-25, 1924, to 10-27, 1924, that I last saw her alive on 10-25, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

6 mo Pregnancy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Hall, M. D.

, 19 (Address) Hale Thorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Bur. Wm. R. WOODALL.

OCT 28 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

32

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91469

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. D 91469

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Caroline McDonald

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Francis Eckels

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Municipal Hospital Records
(Address)

15 OCT 28 1924 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-22, 1924 to 10-23, 1924

that I last saw her alive on 10-23, 1924

and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Detirioration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sob.

(Signed) Claude E. Hinman, M. D.

10-24 19 24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	10/29 1924
20 UNDERTAKER	ADDRESS
J. J. Daley & Sons.	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-001

D 91470

CERTIFICATE OF DEATH.

D 91470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hubert Morgan

(a) RESIDENCE NO. 506 S. Charles ST., WARD Jamaica

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Somerville Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Mathilda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Municipal Hospital Records (Address)

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-16, 1924, to 10-22, 1924 that I last saw him alive on 10-21, 1924 and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sub + Autopsy

(Signed) Claude G. Drane, M. D.

10-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart.	10/28 1924
20 UNDERTAKER	ADDRESS
J. Bakey & Sons	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91471

CERTIFICATE OF DEATH.

96 D 91471

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S Chester ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozalia. Rajcher

(a) RESIDENCE No. 410 S. Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	83	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Nowakowski

(Address) 410 S. Chester Street

15 Filed ..., 19.. ROCCHI R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 24, 1924 to Oct 24, 1924.

that I last saw h alive on Oct 25, 1924

and that death occurred, on the date stated above, at 415 P m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Terminated by Cardiac Asthma

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Samuel S Stein, M. D.

, 1924 (Address) 32 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem.	Oct. 29 1924

20 UNDERTAKER: John M Weber ADDRESS 1803 Bank St

Cor.—1-12-23—M&T—100 Bks.

D 91472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-003

D 91472

REGISTERED NO. D 91472

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S Washington ST., V WARD)

2-FULL NAME Angelus Wheatly

(a) RESIDENCE NO. 226 S Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Oct 20/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Earl J Wheatly

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Clara Krucik

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Earl Wheatly
(Address) 226 S Washington St

15 OCT 28 1924 ROBERT M. KRAUTER, Registrar
Local Parish Priest.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:—
Congenital Depravity
Contusion Right Side

(duration) ..... yrs. ..... mos. 7 ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton (Coroner.) M. D.

Oct 29, 1924 (Address) 704 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct 28 1924
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91473

CERTIFICATE OF DEATH.

57 D 91473

REGISTERED NO.....

1-PLACE OF DEATH University Hospital - Balt.

CITY OF BALTIMORE: (No. 12 ST. Belvieu Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie R Webb

(a) RESIDENCE NO. 4010 Belvieu ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Walter A. Webb

6 DATE OF BIRTH (month, day, and year) Sept 27 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Bridgeport Conn.

PARENTS

10 NAME OF FATHER Robinson

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Unknown

14 Informant R R Webb -
(Address) 4010 Belvieu Ave

15 Filed OCT 28 1924 ROBERT N. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1924, to 10/26, 1924, that I last saw her alive on 10/24, 1924, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Diabetes.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary embolism.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. C. Whaley M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridgeport Conn.	Oct 29 1924
20 UNDERTAKER Harry S Nitzke	ADDRESS 1531 N Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91474

CERTIFICATE OF DEATH.

11 V D 91474

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 419 E. Lyon ST., 14 WARD)

2-FULL NAME Wm H. Grumbling

(a) RESIDENCE No 1328 N. Balto ST., / WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amy Grumbling

6 DATE OF BIRTH (month, day, and year) June 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Highway
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Emanuel Grumbling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lucy Miltendorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Mrs Elsie Gaffney
(Address) 1026 Hollins St

15 Filed OCT 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. 2 hours mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

(Signed) Thos E. Horton, M. D.
(Coroner.)

Oct 26th, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether (2) Accidental, Suicidal, or Homicidal. (See reverse side for additional data.) Balto Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westport Cemetery — DATE OF BURIAL Oct. 29 1924

20 UNDERTAKER George L. Schmidt — ADDRESS 401 Fulton Ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

D 91475 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91475

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1823 Lemon St ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Richard Young

(a) RESIDENCE NO. 1823 Lemon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
–

6 DATE OF BIRTH (month, day, and year) Feb 23, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Robert Fulton Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant R. F. Young
(Address) 1823 Lemon St

15 Filed OCT 31 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1924, to Oct 28, 1924, that I last saw h in alive on Oct 28, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute miliary tuberculosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) cardiac asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edward V. Coolahan, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Oct 30, 1924

20 UNDERTAKER Edw Cook

ADDRESS 502 E Fayette St

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. It may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on ba

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Women's Hospital

City of BALTIMORE: (No. Lafayette & Johns St. 77 Ward) 129

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Virginia Holtz

(a) Residence No. 5223 Florence ave, city St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William A Holtz

6-DATE OF BIRTH (month, day and year) apr. 14 1867

7-AGE, 57 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Washington D.C. (State or Country),

PARENTS.

10-NAME OF FATHER, James Foster

11-BIRTHPLACE OF FATHER (city or town) Lowden County (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Jane Elizabeth Angel Ella Virginia Foster

13-BIRTHPLACE OF MOTHER (city or town) Washington DC. (State or Country).

14-

(Informant) William A. Holtz

(Address) 5223 Florence ave

15- Filed OCT 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-28-1924

17- I HEREBY CERTIFY, That I attended deceased from 10-25-24, 19..., to 10-28, 1924

that I last saw h.. alive on 10-28, 1924,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. Urine exam. Blood Chemistry

(Signed) J. Clyde Warfield, Jr., M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Oct 30, 1924
20-UNDERTAKER, Wm. Cook	ADDRESS 1022 Lanvale

N.B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91477

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 146 N. Potomac St

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Baby Wheeler

(a) RESIDENCE NO. 146 N. Potomac ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. — mos. — ds. How long in U. S., if of foreign birth? 0 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single.

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) 146 N. Potomac St
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. H. Wheeler

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Gladys M. Hall

13 BIRTHPLACE OF MOTHER (city or town) Camden
(State or country) N. J.

14 Informant Father
(Address) 146 N. Potomac St.

OCT 28 1924

Registrar .19 Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1924

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ on
Oct. 28, 1924, to Oct. 29, 1924,
that I last saw him alive on Oct. 28 th, 1924,
and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:
Premature birth.

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Dobihal, M. D.

.19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Oct 29 1924

20 UNDERTAKER Chas. G. Butler & Son — ADDRESS 1834 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91478

CERTIFICATE OF DEATH.

100 001 D 91478

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Willis

(a) RESIDENCE NO. 2119 E Monument WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-26-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George D. Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillie May Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Hospital Records

15 Filed OCT 28 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/1924

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1924 to 10/27, 1924 that I last saw h[illegible] alive on 10/27, 1924 and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2d Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) H. W. McCloy M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 29 1924
20 UNDERTAKER Jno C. Fuller & Son	ADDRESS 1334 Hoffman St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 ✓ D 91479

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Inf. Dom Hosp'l (ST.) (WARD)

2-FULL NAME Baby Meade.

(a) RESIDENCE No. Hampstead Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 10, 26, 24

7 AGE Years ..... Months ..... Days 1 If less than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED ✓

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dewit Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margie Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Dewit Meade (Address) Hampstead Md

15 OCT 28 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10. 27. 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-26-24, 19.., to 10-27-24, 19.., that I last saw h.. alive on 10-27-24 and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Uremia following upon Malaria,

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature birth (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Bonn M.D.

19 (Address) Hampstead Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead Md

DATE OF BURIAL Oct 29 1924

20 UNDERTAKER C. V. Tipton Hampstead Md

ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 91480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+100-00 D 91480

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Macauley Birckhead

(a) RESIDENCE NO. 36 Melvin Ave ST., WARD Catonsville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred approx 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Davis Florence Kelly

6 DATE OF BIRTH (month, day, and year) April 13-1851

7 AGE	73 Years	6 Months	14 Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Birckhead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Macaulay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Simon Birckhead
(Address) Baltimore Md

15 OCT 28 1924, 19 (Robert P. Harrison) Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27, 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 19 24 (10-01) to ....., 19 .....,

that I last saw h.. alive on Oct 27, 19 24 (10-01)

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

..... (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Catonsville Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas O'Donovan M. D.

, 19 (Address) 3 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old St Paul Cemetery	Oct 29 1924
20 UNDERTAKER	ADDRESS
J W Jenkins & Son Co	Orchard & McCulloh

CT 2

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91481

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-98 V

B 91481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 N. Bond. ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie B. Carre

(a) RESIDENCE NO. 1435 N. Bond. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of John Carre

6 DATE OF BIRTH (month, day, and year) ? 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John U Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virgie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Carre

(Address) 1435 N Bond

15 Filed OCT 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct ....., 1922, to Oct 27, 1924.

that I last saw her alive on Oct 27 th, 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) F. J. Kinzey, M. D.

10/28, 1924 (Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Oct 30 1924

20 UNDERTAKER Scott J Turner Jr — ADDRESS 1442 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91482

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glenayle ave ST., 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Davis

(a) RESIDENCE NO. Glenayle ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Davis

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	11	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER James E. Davis

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Geo. H. Little
(Address) 2705 Edmondson

15 Filed OCT 8 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jno. H. Krumm M. D.
(Coroner.)
Oct 28, 1924 (Address) 3632 Parkside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Oct 30 1924

20 UNDERTAKER Geo. H. Little ADDRESS 2705 Edmondson ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91483

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 91483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 772 Allegheny St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Elizabeth Poffenbach

(a) Residence No. 772 Allegheny St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, ~~or divorced~~ HUSBAND ~~of~~ or) WIFE of Arnold F. Poffenbach

6-DATE OF BIRTH (month, day and year) June 23 1840

7-AGE. 84 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Doesch

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unt Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

11- (Informant) Elizabeth Poffenbach

(Address) 772 Allegheny Ave

15- Filed Robert P. Harrison, Registrar.

OCT 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 27, 1924, to Oct 27, 19 24 that I last saw h[er] alive on Oct 27, 19 24 and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

10/28, 1924 (Signed) H. G. Davis M. D.

(Address) 720 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery — DATE OF BURIAL, Oct 30, 19 24

20-UNDERTAKER. Jos Joerdens Son — ADDRESS 217 S. Paca

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91484

CERTIFICATE OF DEATH.

90 D 91484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2143 (St.) Woodbery ave (Ward) 13

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Smith.

(a) RESIDENCE NO. 2143 (St.) Woodbery ave (Ward) 13

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles Smith

6 DATE OF BIRTH (month, day, and year) May 5 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER James Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Fannie Decker
(Address) 2143 Woodbery ave

15 Filed Oct 28 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CT 28 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Labouhar Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Monroe, M. D.
(Coroner)

Oct 28, 1924 (Address) 7632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 29 1924
20 UNDERTAKER	ADDRESS
UNKNOWETH & SON	3617 CHESTNUT AVE.

AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE
that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that
tions on back of certificate. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91485

CERTIFICATE OF DEATH.

D 91485

REGISTERED No. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N Spring ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara E. Ruffner

(a) RESIDENCE No. 416 N. Spring St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J.L.Fuffner

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Columbus Ohio

PARENTS

10 NAME OF FATHER Wm. J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) nknown

12 MAIDEN NAME OF MOTHER Mary E.Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant J.L.Ruffner
(Address) 416 N. Spring St

15 Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

17 The CAUSE OF DEATH* was as follows:
Thoracic Hemorrhage

Probable Aneurism (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pro ably Leuetic (duration) ... yrs. ... mos. ... ds.

(Signed) J. L. Fuffner, M. D.
(Coroner.)
10/28/24, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel County	10/29/ 1924
20 UNDERTAKER Byron Wright	ADDRESS 1218 McElderry st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91486

CERTIFICATE OF DEATH.

3 D 91486

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE, (No. 326 S Payson St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka A. Wessman

(a) Residence No. 326 S Payson St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE William Wessman

6-DATE OF BIRTH (month, day and year) Jan 12 1873

7-AGE 51 yrs. 9 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HW

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Tony Geyser

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Wissel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-INFORMANT (Informant) Wm Wessman

(Address) 326 S Payson

15-Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25-24

17-I HEREBY CERTIFY, That I attended deceased from Oct 18 24 to Oct 25 24, 19..., that I last saw her alive on Oct 25 24, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? None Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? None

(Signed) Emil G Schwarz M. D.

, 19 (Address) 1 Mt Vernon Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Oct 29th 24
20-UNDERTAKER.	**ADDRESS**
Harry Mc Intyre	Gilmor & Lombard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3rd D 91487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Petrij

(a) RESIDENCE NO. 2046 E. Hoffman St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Aloysius Petrij

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ida Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Aloysius Petrij

(Address) 2046 E. Hoffman St

15 Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to Oct. 28, 1924, that I last saw him alive on Oct. 28, 1924, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (Tuberculous)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hom

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 30, 1924
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91488

CERTIFICATE OF DEATH.

100-001 D 91488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 E. Eager ST., 10 WARD)

2-FULL NAME Thelma E. George

(a) RESIDENCE NO. 1222 E. Eager ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	5	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co. (State or country) Md.

PARENTS

10 NAME OF FATHER William S. George Jr.

11 BIRTHPLACE OF FATHER (city or town) Talbot Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Burkinshaw

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Md.

14 Informant M. William S. George Jr. (Address) 1222 E Eager St

15 Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25 1924 to Oct. 29 1924 that I last saw h[illegible] alive on Oct. 29, 1924 and that death occurred, on the date stated above, at 3.08 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Emphysema from Pneumonia

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) I. Benj. S. Hayden M. D.

10/26 1924 (Address) 1256 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Md.	Oct. 30 1924
20 UNDERTAKER	ADDRESS
Henry Hosch & Son	1301 E Eager St

B. B. & A. Board

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

FILM

Spec—12-23-21—E.B.R.S.—400 Bks.

91489 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

91489 D

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 78 Ward) 91-00

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mrs Anne Mahoney

(a) Residence No. Mt Hope Retreat St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Mahoney

6-DATE OF BIRTH (month, day and year) Dec 25

7-AGE, Last 71 yrs. 6 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), (?) Ireland

PARENTS.

10-NAME OF FATHER, James Kelcher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), (?) Ireland

12-MAIDEN NAME OF MOTHER, Surrey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), (?) Ireland

14- (Informant) Records of Institution

(Address) Mt Hope Balto Md

15- Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 6th 1921, to Oct 28, 1924, that I last saw h.er alive on Oct 27, 1924, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Chr Arteria Sclerosis

abt (Duration) 3 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (Duration) 3 yrs. 6 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL, Oct. 30, 1924

20-UNDERTAKER, Henry Hoch Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91490

D 91490

CERTIFICATE OF DEATH.

REGISTERED NO. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 E. Cross ST. 24 WARD)

2-FULL NAME Edith Cripps

(a) RESIDENCE No. 313 E Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) July 11 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James F Cripps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edith B Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs James F Cripps (Address) 313 E Cross St

15 Filed OCT 29 1924 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924, to Oct 28, 1924, that I last saw her alive on Oct 28, 1924, and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Stenosis of the Pylorus

(duration) yrs. 3 mos 17 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical

(Signed) John L. Fruchy, M. D.

10/25, 1924 (Address) 3522 Freemont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct 30 1924

20 UNDERTAKER John F Dammy — ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 8 89

City of BALTIMORE: (No. 1534 N. Bond St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. McCullough

(a) Residence No. 1534 N. Bond St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Oct 26/92

7-AGE. 32 yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): D23

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS.

10-NAME OF FATHER: John W. Cullough

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Elizabeth S. Black

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant): John W. Cullough

(Address): 1534 N. Bond

OCT 29 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct 27/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 25th 24 to Oct 27th 24

that I last saw him alive on Oct 26th 24

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Hoard M. D.

(Address) 1501 E. Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	10/29, 1924
20-UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 91492

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 S Green St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Editly Pemberton

(a) Residence No..... 707 S Green St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 20 1920

7-AGE, 4 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town)..... (State or Country), Va

PARENTS.

10-NAME OF FATHER, Cornelus Pemberton

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va

12-MAIDEN NAME OF MOTHER, Irene Pemberton

13-BIRTHPLACE OF MOTHER (city or town)... Va (State or Country),

14-

(Informant)..... Cornelus Pemberton

(Address)..... 707 S Green St.

15-

OCT 29 1924

ROBERT P. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/27/24

17- I HEREBY CERTIFY, That I attended deceased from 10/24/24, 19..., to 10/27/24, 19..., that I last saw h... alive on 10/27th 24, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Abt 1

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism Abt 2 (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Ray Bowen, M. D.

10/28, 19 24 (Address) 908 Shaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Zion Ch. DATE OF BURIAL, Oct 29, 1924

20-UNDERTAKER, S. W. Brown & Son ADDRESS 1081 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91493

CERTIFICATE OF DEATH.

8 31

D 91493

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1208 N Patterson Park Ave ..... Ward) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Concannon

(a) Residence No. 1208 N. Patterson Park Ave ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Concannon

6-DATE OF BIRTH (month, day and year) May - 1859

7-AGE, 65 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Richard Concannon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sabina Brien

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Elizabeth Concannon

(Address) 1208 N Patterson Park Ave

15- Filed OCT 29 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 28 1924.

I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 24 to Oct 28, 19 24

that I last saw h.. alive on Oct 27, 19 24

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) H F Kenny M D, M. D.

(Address) 1305 N Patterson Pk Oct 28, 19 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Oct 31, 19 24

20-UNDERTAKER, W. P. Wiedefeld — ADDRESS 914 Grummet Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91494

CERTIFICATE OF DEATH.

+46 D 91494

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Helen Wilder.

(a) RESIDENCE NO. 2102 Pyle Lane Wilmington Del. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 048

(b) General nature of industry, business, or establishment in which employed (or employer) Nurse

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records

(Address)

15 Filed OCT 29 1924 ROBERT P. KRAUTER, Registrar

Registrar's Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28/24

17

I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 5/1/24, 19..., to 10/28/24, 19...

that I last saw ~~him~~ alive on 10/26/24, 19...

and that death occurred, on the date stated above, at 7.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tobacco

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical-operation

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del DATE OF BURIAL 10/29/24

20 UNDERTAKER Boyd & Turley Fulton ADDRESS Lafayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

Crawford

D 91495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

01-001

D 91495

Registered No.....

1-PLACE OF DEATH Church Home and Infirmary

City of BALTIMORE: (No. Fairmount & Broadway St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Crawford

(a) Residence No. 121 Chesapeake St. Williamsport Va. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Sept 4th 1881 ?

7-AGE. 43 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) ? 066

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Wilbur Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Susan Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Mrs. Geraldine Massey

(Address) Normandie Apts

OCT 29 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1924 to Oct 28 1924

that I last saw him alive on Oct 28 1924

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Keith G Rose M. D

, 19 (Address) Church Home & Inf.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Williamsport Pa

DATE OF BURIAL. Oct 30th 1924

20-UNDERTAKER. Henry H Jenkins Sons

ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91496

CERTIFICATE OF DEATH.

X 129

D 91496

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 121 Braxton St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Enguna

2-FULL NAME Nancy Funeman

(a) Residence No. 121 Braxton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or mio.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Dick Tarson

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Dick Tarson

12-MAIDEN NAME OF MOTHER Dick Tarson

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Dick Tarson

14- (Informant) Mrs Hunt

(Address) 121 Braxton St

15-

Filed OCT 29 1924 193

ROBERT A. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 26-24

17- I HEREBY CERTIFY, That I attended deceased from October 3 - 1924 to October 26 1924

that I last saw her alive on October 26 1924

and that death occurred, on the date stated above, at 10,45 P m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 1 yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? Atlantic City N.J.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. A. M. Kennard M. D.

10-27 1924 (Address) 708 Esser Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Lawn Cem	10-29-24
20-UNDERTAKER.	ADDRESS
Dan Tarson	Vernon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91497

CERTIFICATE OF DEATH.

90 D 91497

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 S. Bouldin St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Pocock,

(a) Residence No. 517 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles E. Pocock

6-DATE OF BIRTH (month, day and year) Feb. 20-1858

7-AGE, 66 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, Edw. Voelker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14-

(Informant) Adelene C. Jones

(Address) 517 S. Bouldin St

15- OCT 29 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 27-1924.

17- I HEREBY CERTIFY, That I attended deceased from October 5 1924 to October 27 1924

that I last saw her alive on October 27 1924

and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Pilley M. D

19 (Address) 100 S. Potteron Parkway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Schwartze — DATE OF BURIAL. Oct 31 1924

20-UNDERTAKER. Zirkler + Zirkler — ADDRESS 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91498

CERTIFICATE OF DEATH.

90 D 91498

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Frederick Ave ST., 20 WARD)

2-FULL NAME Edward B. Martin

(a) RESIDENCE No. 1907 Frederick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie C. Martin

6 DATE OF BIRTH (month, day, and year): April 15th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Smith W. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizabeth Knoch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Fannie C. Martin

(Address): 1907 Frederick Ave

15 Filed OCT 29 1924 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1924, to Oct 27, 1924, that I last saw h-e alive on Oct 27, 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Heart disease

..... (duration) ..... yrs. intense mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Signs Symptoms

(Signed) Walter Clay, M. D.

Oct 29, 19.. (Address) 2406 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 29 1924

UNDERTAKER: George L. Schwab — ADDRESS: 1101 Druid Hill Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Viccio

D 91499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91499

101-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No.) 1000 Granby St. (St.) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margueth Viccio

(a) Residence No. 1000 Granby St. (St.) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. 2 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Aug 13 1916

7-AGE. 8 yrs. 2 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Vincent Viccio

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Viccio

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Vincent Viccio

(Address) 1000 Granby St

OCT 29 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1924 to Oct 27, 1924

that I last saw her alive on Oct 27, 1924

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Testa, M. D.

, 19 (Address) 240 Pearl St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 30. 1924

20-UNDERTAKER: Wendell Zeppelin — ADDRESS: 37 S Linwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Allers

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91500

CERTIFICATE OF DEATH.

D 91500

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1144 Lamar St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William August Allers

(a) Residence No. 244 Lamar St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Louise

6-DATE OF BIRTH (month, day and year) Oct 4, 1861

7-AGE. 63 yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Store

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Herman Allers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Regina Ritter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Mrs Louise Allers

(Address) 244 Lamar St

15- Filed OCT 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 27. 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 19 24 to Oct 27 19 24

that I last saw him alive on Oct 24 19 24

and that death occurred, on the date stated above, at 6-30 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry Boyd M. D

Oct 27. 1924 (Address) 602 Washington Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem DATE OF BURIAL. Oct 30 1924

20-UNDERTAKER. J. W. Cole ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91501

CERTIFICATE OF DEATH.

113 D 91501

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 f r Camel ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luella Wilson

(a) RESIDENCE NO. 3 f 2 Camel ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Auburn

11 BIRTHPLACE OF FATHER (city or town) ✓ (State or country)

12 MAIDEN NAME OF MOTHER Auburn

13 BIRTHPLACE OF MOTHER (city or town) ✓ (State or country)

14 Informant Thomas Wilson

(Address) 3 f 2 Camel St.

Filed OCT 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 1924

17 Oct

I HEREBY CERTIFY, That I attended deceased from Sept 26 1924, to Oct 27th 1924, that I last saw her alive on Oct. 26th 1924, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Foster - Endocarditis

(duration) yrs. ..... mos. 1 mo ds.

CONTRIBUTORY (Secondary) Streptococcus Infection

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

1924 (Address) 42 f Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Embryological Lab.

DATE OF BURIAL 19

20 UNDERTAKER ✓

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JOHNSON

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91502

D 91502 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1329

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Lyndhurst Av ST. 15 WARD)

2-FULL NAME John C. Johnson

(a) RESIDENCE. NO. 2210 Lyndhurst Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Emma L. Johnson

6 DATE OF BIRTH (month, day, and year) Jan 14, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain ofb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sanford & Brooks

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norway

14 Informant Emma L. Johnson

(Address) 2210 Lyndhurst Ave

Filed OCT 29 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Oct. 28, 1924

that I last saw him alive on Oct. 28, 1924

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Hypertension. Chr. Nephritis

~~Cerebral Hemorrhage~~

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Residence.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. Craig Jr. M. D.

10/27, 1924 (Address) 1007 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 31, 1924
20 UNDERTAKER Harry Crook	ADDRESS 1007 E Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91503

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH Church Home and Infirmary

City of BALTIMORE: (No. Fairmount and Broadway St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hall Cowdrey

(a) Residence No. Carlisle Penn St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 21, 1876

7-AGE. 48 yrs. 0 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Holly Springs (State or Country), Miss.

PARENTS.

10-NAME OF FATHER, Stephen Cowdrey

11-BIRTHPLACE OF FATHER (city or town) Plymouth (State or Country), N.H.

12-MAIDEN NAME OF MOTHER, Mary Hall

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Miss Ruth Cowdrey

(Address) Carlisle Pa.

15-

Filed ..... 19 Robert P. Harrison, Registrar.

OCT 29 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 28. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1924, to Oct 28 1924, that I last saw h.r alive on Oct 28 1924, and that death occurred, on the date stated above, at 2:33P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Keith L. Rice M. D

19 (Address) Church Home Inf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Carlisle Pa.	Oct. 30, 1924
20-UNDERTAKER N E Hughes	ADDRESS 424 N. Broadway

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91504

CERTIFICATE OF DEATH.

REGISTERED NO. 1291

1-PLACE OF DEATH 800 Reservoir St.

CITY OF BALTIMORE: (No. Jerome Apts. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Schwartz

(a) RESIDENCE NO. Jerome Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Schwartz

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1859.

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. Railroad.

9 BIRTHPLACE (city or town) Richmond. (State or country) Va.

PARENTS

10 NAME OF FATHER Schwartz

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Julius Schwartz (Address) Jerome Apts.

15 Filed Oct 29 1924 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

CT 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28/24. 19

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923, to Oct 28, 1924, that I last saw h[illegible] alive on Oct 28, 1924, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Ernest E. Magruder, M. D.

10/29, 19 24 (Address) Hotel Splendor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship's Hebrew [illegible] Cemetery

DATE OF BURIAL 10/30/ 1924

20 UNDERTAKER David Sondheim

ADDRESS 118-2010. Mt. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91505

CERTIFICATE OF DEATH.

6 74 001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1506 Orleans St., 6 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Rockhold

(a) Residence No. 1506 Orleans St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L Rockhold

6-DATE OF BIRTH (month, day and year) June 4th 1841

7-AGE, 83 yrs. 4 mos. 27 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Fowler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Co. Md

12-MAIDEN NAME OF MOTHER, Matilda Nichols

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co Md

14- (Informant) J Fred Rockhold

(Address) 424 N. Milton ave

15- Oct 29 1924 Robert P. Harrison, 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). October 28. '24

17- I HEREBY CERTIFY, That I attended deceased from January 10. 1924 to October 28, 1924.

that I last saw h. alive on ... 1924

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George W. Hartman, M. D.

Oct. 29, 1924 (Address) 2214 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, Oct 31st 1924

20-UNDERTAKER, George Schilling & Sons ADDRESS 1126 E Monument st

OCT 29 1924

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91506

CERTIFICATE OF DEATH.

90 D 91506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Bond St ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Blanks

(a) RESIDENCE NO 214 N Bodd St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Blanks

6 DATE OF BIRTH (month, day, and year) Feb 15/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Zachary Blanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma Blanks
(Address) 916 Watson St

15 FILED OCT 29 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Insuffiuiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exposure & lack of nutrition

(duration) yrs. mos. ds.

(Signed) J. S. Carter, M. D.
(Coroner.)

10/29/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetary	Oct 30th 192 4
20 UNDERTAKER	ADDRESS
Harry H. Wolfe Funeral Director	Belmar

I.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91507

CERTIFICATE OF DEATH.

129 D 91507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5219 1/2 York Road ST., 6 WARD)

2-FULL NAME Franklin M. Garver

(a) RESIDENCE NO. 5219 1/2 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Nellie Garver

6 DATE OF BIRTH (month, day, and year) 12-25-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) of Customs 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER John Garver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza M. Lehmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nellie Garver

(Address) 5219 1/2 York Road

15 Filed OCT 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Octr 24, 1924, to Octr 28, 1924, that I last saw him alive on Octr 28, 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Parenchymatous Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. L. Bishop M. D.

Oct 29 1924 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md — DATE OF BURIAL Oct 31 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E. 50th

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1742 E. Balto st St., 6 Ward) 101

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Margolis

(a) Residence No. 1742 E Balto St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Margolis

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 73 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Shechter

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

086

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Alexander Margolis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Israel Margolis

(Address) 2416 Liberty Heights Ave

15- OCT 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 29/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1924 to Oct. 29, 1924

that I last saw him alive on Oct 28 1924

and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Croupous (Lobar) Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Franklin Lucke M. D.

10/29. 1924 (Address) 927 N. Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Southern Ave

DATE OF BURIAL, 10/29/1924

20-UNDERTAKER. Sol Levinson & Bro

ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 91509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Hudson ST., 1 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Spence

(a) RESIDENCE No 2917 Hudson ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kennett Spence

6 DATE OF BIRTH (month, day, and year) May 2 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER John Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Judd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Kennett Spence
(Address) 2917 Hudson St

15 Filed OCT 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fulton, M. D.
(Coroner.)

Oct 29 1924 (Address) 701 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Oct 30 1924

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pleasant

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Lockard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91510

CERTIFICATE OF DEATH.

D 91510

1-PLACE OF DEATH

City of BALTIMORE: (No. Eagewood Sanatarium St., 7 Ward) Belona ave Govans

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Jones

(a) Residence No. Belona ave Govans St., Ward Govans Park Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) June 4. 1870

7-AGE. 54 yrs. 4 mos. 25 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, J. Thomas Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), A. A. Co. Md.

12-MAIDEN NAME OF MOTHER, Mary Gambrill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Howard Co Md

14- (Informant) James T. Blays

(Address) 8 N. Read St

15- Filed OCT 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 29. 24

17- I HEREBY CERTIFY, That I attended deceased from April 26 1924 to Oct 29 1924

that I last saw him alive on Oct 29 1924

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Parotid Gland, involving tissues of neck thereof.

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Glanders & Tetania

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard M. D.

Oct 29. 1924 (Address) 4 E. Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Oct. 30 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 120 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 91511
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 B 91511
Registered No.

City of BALTIMORE: (No. 1920 N. Saratoga St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma R. Hamburger

(a) Residence No. 1920 N. Saratoga St., Ward
(Usual place of Abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hamburger

6-DATE OF BIRTH (month, day and year) May 16 1868

7-AGE. 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). at home
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS:
10-NAME OF FATHER. Daniel Stemfuser
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.
12-MAIDEN NAME OF MOTHER. Anna Wenker
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Cora H. Schaffer
(Address) 1920 N. Saratoga St

15-Filed OCT 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 28 1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1924 to Oct 27, 1924
that I last saw h 2 alive on Oct 27, 1924
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolus

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj. Headen M. D.
, 19 (Address) 2306 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery — DATE OF BURIAL. Oct 30, 1924

20-UNDERTAKER. John C. Mitchell — ADDRESS 1320 W. Fayette St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91512

CERTIFICATE OF DEATH.

D 91512

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5302 Park Heights Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. RIce

(a) Residence No. 5302 Park Heights Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 6 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of LeRoy S. Rice

6-DATE OF BIRTH (month, day and year) April 1898

7-AGE. 26 yrs. 6 mos. ? ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Rose

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Mary Cumberland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington, D. C.

14-Informant (Informant) Mrs. John W. Gaffney

(Address) 5302 Park Heights Ave.

15-Filed OCT 30 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-25-24

17- I HEREBY CERTIFY, That I attended deceased from 7-1-24 to 10-25 19 24

that I last saw h[illegible] alive on 10-27 19 24

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Epilepsy conducted

Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema Lung

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Syndrome

(Signed) Fred Cumberland M. D.

(Address) 600 N Matt Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Oct. 31 19 24
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son,	805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 91513

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1716 N. Calvert St., ... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. Ida Parks DeBaugh .....

(a) Residence No..... 1716 N. Calvert St., ... St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. 6 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Philip A. DeBaugh

6-DATE OF BIRTH (month, day and year) May 21, 1854

7-AGE. ..70.. yrs. ..6.. mos. ..7.. ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore Co (State or Country), Maryland

PARENTS.

10-NAME OF FATHER William Parks

11-BIRTHPLACE OF FATHER (city or town) Balto., Co., (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellenore Cole

13-BIRTHPLACE OF MOTHER (city or town) Balto., Co., (State or Country), Maryland

14- (Informant) Mrs Ella Waram

(Address) 1716 N. Calvert St.

15- OCT 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct., 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from July, 19 24, to Oct 28, 19 24, that I last saw h.. alive on Oct 28, 19 24, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C. B. Hamilton Jr, M. D.

, 19 (Address) 2427 Barclay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Prospect Hill, Towson

DATE OF BURIAL, 10/30, 1924

20-UNDERTAKER. H W Means & Son

ADDRESS Baltimore Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Bks.

Hochmal

D 91514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Eager Place ST., 7 WARD)

2-FULL NAME Marie Hobmal

(a) RESIDENCE No. 2332 Eager Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Hobmal

6 DATE OF BIRTH (month, day, and year): Oct. 15, 1845

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Zelesni Brode Czecho-Slovakia

10 NAME OF FATHER: Jan Muzanec

11 BIRTHPLACE OF FATHER (city or town) (State or country): Czecho-Slovakia

12 MAIDEN NAME OF MOTHER: Emma Jehova

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Czecho-Slovakia

14 Informant: Emma Novak

(Address) 2332 Eager Pl

15 Filed OCT 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1924, to Oct. 29, 1924, that I last saw her alive on Oct. 29, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Novak, M.D.

, 19 (Address) 875 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — DATE OF BURIAL: Nov 1 1924

20 UNDERTAKER: Grant Ecroet Son — ADDRESS: 1906 Eastern Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 91515

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 727 Pennington St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Michora (Mechura)

(a) Residence No. 727 Pennington Ave St., 25 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Michora

6-DATE OF BIRTH (month, day and year) June 1889

7-AGE 35 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER Joseph Michora

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER Mary Yecha

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14-(Informant) Joseph Michora

(Address) Curtis Bay Baltimore

15-Filed OCT 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 28-1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 26 1924 to Oct 28 1924

that I last saw h— alive on Oct 28 1924

and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leon D. Flora M. D

Oct 28 1924 (Address) Curtis Bay Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross	Oct 31, 1924

20-UNDERTAKER.	ADDRESS
Frank Crockett	1906 Carlton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Ehudin

HEALTH DEPARTMENT—CITY OF BALTIMORE

4003

CERTIFICATE OF DEATH.

D 91516

88 D 91516

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

2-FULL NAME Ethel Ehudin

(a) RESIDENCE No. 1828 Druidman Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 0-27
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14
Informant Jack Lewis
(Address) 1828 Druidman Ave

OCT 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Hs death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull. Broken Larm + R. Leg

(duration) A few hours

CONTRIBUTORY (Secondary) Struck by auto
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Fouch, M. D.
(Coroner.)

10 29, 1924 (Address) 1117 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 10-30 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1828 Druidman Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91517

CERTIFICATE OF DEATH.

D 91517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital ST., No WARD)

2-FULL NAME George E. Smith

(a) RESIDENCE NO Hale Harpe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Whit	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Painter Salts city

9 BIRTHPLACE (city or town) (State or country) Smild

PARENTS

10 NAME OF FATHER Smild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant ..... (Address) .....

15 Filed OCT 30 1924 ROBERT A. KRAUTER, Registrar

THE MORGUE Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

of 3 mos + must be baby, Stark mad Dr. when sitting on [illegible] accident

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W Fenton, M. D. (Coroner.)

Oct 28 1924 (Address) 1002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Hale Harpe

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Oct 29 1924

20 UNDERTAKER [illegible] Health.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91518 X185 D 91518

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Frank 9days Bonsal

(a) RESIDENCE NO. Moulton, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1r ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elinor Stewart Bonsal

6 DATE OF BIRTH (month, day, and year) July 7, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Stephen Bonsal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Leigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Miles White

(Address) 1620 N Calvert St

Filed OCT 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28. 1924.

17

I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Oct. 28, 1924, that I last saw him alive on October 28, 1924 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

J. K. Corner J. Morrissey

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Fractured clavicle

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clay

(Signed) Edwin O. Jarrett, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cem Garrison Forest	Oct 30, 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	Orchard & McCulloh

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

1924 91519

CERTIFICATE OF DEATH.

+123 D 91519

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Jean Greenberg

(a) RESIDENCE No. Newark N. J. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 7 mos. ..... ds. How long in U. S., if of foreign birth? 35 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Irving Greenberg

6 DATE OF BIRTH (month, day, and year): May 10-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

145

9 BIRTHPLACE (city or town) (State or country): Roumania

PARENTS

10 NAME OF FATHER: Osias Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Roumania

12 MAIDEN NAME OF MOTHER: Henetta Siegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Roumania

14 Informant: Records

(Address)

15 OCT 30 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 18 -, 1924, to Oct 30 -, 1924, that I last saw h... alive on Oct 30 -, 1924, and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction, Chr.

(duration) yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary): Gall stone - common duct (duration) yrs. 1½ mos. ..... da.

18 Where was disease contracted if not at place of death? Newark N.J.

Did an operation precede death? Yes Date of 9/30/24 10/30/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A.W. Sinberg, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bnai Jeshurun Cem. Elizabeth, N. J.

DATE OF BURIAL: 10/30/1924

20 UNDERTAKER: David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91520

CERTIFICATE OF DEATH.

179 D 91520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

2-FULL NAME Anna Green

(a) RESIDENCE NO. 2108 Ridgewood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 2 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia Pa.
(State or country)

PARENTS

10 NAME OF FATHER Abe Green

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Casper

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Abe Green
(Address) 2108 Ridgewood Ave

15 Filed OCT 30 1924 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st & 2nd degree burns of body; (duration) ... yrs. mos. 5 hrs. ds.

CONTRIBUTORY (Secondary) accidental, falling into tub of hot water. (duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Oct. 30, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2108 Ridgewood Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 10/30 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 112 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—10-21—M&T—1500 Bks.

D 91521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91521

16-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital.

CITY OF BALTIMORE: (No. Payson ave & Lakeland st. ST. 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gross.

(a) RESIDENCE NO. 910 Laral Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 24, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Foote

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gross

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Maryland

14 Informant Mary Gross
(Address) 910 Laral Ave

15 Filed OCT 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 19 24.

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924, to Oct 29, 1924, that I last saw him alive on Oct 29, 1924, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery.

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Mal-nutrition.

(duration) ... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Biological

(Signed) Chas. R. Morris, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Oct. 30, 1924.

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Chester Wyrobek)

D 91522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D 91522

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S. Wolf ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester Wyrobek

(a) RESIDENCE NO. 416 S. Wolf ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Walter . Wyrobek

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Anna. Truszki

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mrs. Anna. Wyrobek

(Address) 416 S. Wolfe Street

15 OCT 30 1924 AGNES M. KRAUSER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-29 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Oct. 29, 1924, that I last saw him alive on Oct 28, 1924, and that death occurred, on the date stated above, at 2.20 A.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: 10/30/24

20 UNDERTAKER: John Walter ADDRESS: 1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should strike CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91523

CERTIFICATE OF DEATH.

1924 D 91523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cyrus Carey Jr.

(a) RESIDENCE NO. 1731 Carlisle Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Delta, Pa

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delta, Pa.

PARENTS

10 NAME OF FATHER Cyrus Carey Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Gilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Cyrus Carey Sr.
(Address) Delta, Pa.

15 OCT 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General peritonitis and sepsis due to pistol shot wound of chest.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy (Coroner.), M. D.

Oct. 28 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa. DATE OF BURIAL Oct 30 1924

20 UNDERTAKER J. Mac P. G. Elliott ADDRESS 1225 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 91524

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sophie Johenning

(a) Residence No..... Preston & Valley Sts. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Feb 2 - 1854

7-AGE, 70 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Joehenning

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Christina Grohn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Sister Florence

(Address) Preston & Valley

15- OCT 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 29/24

17- I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h.. alive on Oct 16, 19 24,

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Gangrene of foot

1 week (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

Unknown (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. A. Arma, M. D.

29, 19 24 (Address) 1133 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 31, 1924
20-UNDERTAKER.	**ADDRESS**
H. C. Wiedefeld & Son	Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91525

CERTIFICATE OF DEATH.

100-004

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 939 W. Lombard St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Luther Matthews

(a) Residence No. 939 W. Lombard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 24, 1923

7-AGE, ...yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James L. Matthews

11-BIRTHPLACE OF FATHER (city or town) Dorchester County
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Hattie Elizabeth Johnson

13-BIRTHPLACE OF MOTHER (city or town) Dorchester Co.
(State or Country), Maryland.

14- (Informant) James L. Matthews

(Address) 939 W. Lombard Street

15- Filed ....., 19.... Robert P. Harrison, Registrar.

Burial Permit Given

CT 3 01924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1924 to Oct. 29, 1924 that I last saw him alive on Oct. 29, 1924 and that death occurred, on the date stated above, at 2.45 A.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.

(Duration) — yrs. — mos. 5 3 ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination

(Signed) Thos. Jenkins, M. D.

10-29 1924 (Address) 888 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. | DATE OF BURIAL, Oct 31 1924

20-UNDERTAKER, Joseph L. Bosk | ADDRESS 903 W. Lex St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91526

CERTIFICATE OF DEATH.

28 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 Mallow Hill Avenue St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Emanuel Poole

(a) Residence No. 11 Mallow Hill Avenue St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elexina Poole

6-DATE OF BIRTH (month, day and year) Apr. 17, 1850

7-AGE, 74 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... Davidson Chemical Co.

9-BIRTHPLACE (city or town)..... Brunswick
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Poole

11-BIRTHPLACE OF FATHER (city or town) Brunswick
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lydia Ebbert

13-BIRTHPLACE OF MOTHER (city or town) Brunswick
(State or Country), Maryland

14-

(Informant)... Mrs. Ida B. Hard

(Address)..... 11 Mallow Hill Ave.

15-

Filed ..... Robert P. Harrison, Registrar.

OCT 30 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st, 19 24, to Oct 29, 19 24

that I last saw h.. alive on... Oct 29, 19 24

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Indefinite (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation Pulmonary Edema

(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Harry Glassman, M. D.

10-29-24 (Address) 2687 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL, Oct 31, 1924

20-UNDERTAKER, Joseph B Cook | ADDRESS 1003 N. Dallas St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91527

CERTIFICATE OF DEATH.

D 91527

1-PLACE OF DEATH Howard A Kelly Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Henry Dauber

(a) RESIDENCE NO. Mascoutah Ill. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Marie K. Rauth

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mascoutah, Ill.

PARENTS

10 NAME OF FATHER Louis Dauber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Bettie Merck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Marie K. Dauber (Address) Mascoutah Ill.

15 OCT 30 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1924. to Oct. 30, 1924.

that I last saw him alive on Oct. 30, 1924.

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Oct 30 24

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Grant Edward. M. D.

. 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mascoutah Ill. DATE OF BURIAL Oct 30 1924

20 UNDERTAKER Chas G. Black ADDRESS 142 W. North ave

MARGIN RESERVED FOR BINDING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1765 91528 D 91528

CERTIFICATE OF DEATH. X 51

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Litwin

(a) RESIDENCE No. 2213 E Gonbas/ St., WARD Machonn p t

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
16	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Peter Litwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Martha Panya

13 BIRTHPLACE OF MOTHER (city or town) Lithuania (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

CT3 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924. to Oct 28, 1924.

that I last saw him alive on Oct 28, 1924,

and that death occurred, on the date stated above, at 8 10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Rheumatic Endocarditis

(duration) 5 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 31, 1924
20 UNDERTAKER	**ADDRESS**
Chas. B. Buchanan	637 S Paca St.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~B~~ 91529 (13)

JOHNS HOPKINS HOSPITAL

B 91529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Campbell Mine

(a) RESIDENCE NO. 110 S Myrtle ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 4 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vorchen Mine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alva Mayo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 30 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Oct 29, 1924, that I last saw him alive on Oct 29, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

about

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 24, 1924

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.

10/30, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loreas Meckenburg Co Va — DATE OF BURIAL Oct 31 1924

20 UNDERTAKER J. M. Shulem — ADDRESS 1309 Druid Hill

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91530 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91530

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital 3 Registered No. 44

City of BALTIMORE: (No. Bay View Asylum St., ...Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antoni Sokolowski.

(a) Residence No. 1616 Bethel Place St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.
10-NAME OF FATHER Louis Sokolowski
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland
12-MAIDEN NAME OF MOTHER Frances (unknown)
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14-(Informant) Hospital Records
(Address) Bay View Hospital

15-

OCT 30 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-29-24

17- I HEREBY CERTIFY, That I attended deceased from 9-20-24, 19.... to 10-29 19 24
that I last saw h[illegible] alive on 10-29 19 24
and that death occurred, on the date stated above, at 12.15 A.
The CAUSE OF DEATH* was as follows:
Advanced Carcinoma
of stomach & metastasis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Gastric & Lab tests
(Signed) Dr R Chandler Hendley
Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL. Oct 31 1924

20-UNDERTAKER. Wilhelm Jaworski ADDRESS 1618 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91531

CERTIFICATE OF DEATH.

Registered No. 117

1-PLACE OF DEATH
City of BALTIMORE: (No. St. Joseph's Hosp St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louise Waldau

(a) Residence No. 201 Goodwood Road St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE Frederick G Waldau

6-DATE OF BIRTH (month, day and year) July 2 1860

7-AGE. 64 yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.
10-NAME OF FATHER Frederick Herman
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER Johanna E Prinz
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) A H Waldau
(Address) 1725 E - 33rd St

15-Filed OCT 30 1924, 192 Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3 1924 to Oct. 30 1924 that I last saw her alive on Oct. 30 1924 and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:
Cholelithiasis + cholecystitis
Chr. Appendicitis, Bronchitis
Cardiac hypertrophy
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute cardiac delatation 20 min
(Duration) yrs. mos. 6

18-Where was disease contracted if not at place of death? 201 Goodwood Rd.
Did an operation precede death? Yes Date of 10/20/24
Was there an autopsy? No.
What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Dyberk M. D.
, 18 (Address) St Joseph's Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn — DATE OF BURIAL, Nov 1, 1924

20-UNDERTAKER. J. C. Cook — ADDRESS 5028 Harford Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

INK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91532

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-B 91532

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Riggs Ave. ST. 16 WARD)

2-FULL NAME John W. Clarence Rohmer

(a) RESIDENCE NO. 2600 Riggs Ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 5-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	—	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Rohmer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Phelps

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co
(State or country) Md.

14 Informant Clarence Rohmer
(Address) 2600 Riggs av.

15 Filed OCT 30 1924, 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 21 1924, to October 29, 1924, that I last saw h[illegible] alive on October 28, 1924, and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) — yrs. 3 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

10-30 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenhill Cem. Co. DATE OF BURIAL Oct 31 1924

20 UNDERTAKER J. M. Cook ADDRESS 5028 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 11-001 91533

D 91533

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 Cedar Ave. ST.: 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Clifford Jarrett Jr.

(Residence in Baltimore: No. 126 Cedar Ave. Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W	Single

6-DATE OF BIRTH, Aug (Month) 9 (Day) 1920 (Year)

7-AGE, 4 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, J. C Jarrett

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Margorth Nagel

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C Jarrett

(Address) 126 Cedar Ave

15- Robert P. Harrison, Clerk.

Filed OCT 30 1924, 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1924 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct - 28 1924, to Oct - 30 1924, that I saw him alive on Oct - 30 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Probably Influenza

(Duration) 1 yrs. mos. 1 ds.

Death Unattended

CONTRIBUTORY. (Secondary)

(Duration) 0 yrs. mos. 6+ ds.

(Signed) M. Gibson Fiske M. D.

10/30, 1924 (Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE. (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Western — DATE OF BURIAL, Oct 31, 24

20-UNDERTAKER W. H. Cook — ADDRESS 502 Hollins

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. PHYSICIANS, in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91534

CERTIFICATE OF DEATH.

100-D 91534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 S Eutaw St., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer Wessley — (Murray)

(a) RESIDENCE NO 1016 S Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country) Nat. Murray

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Wessley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hilda Wessley
(Address) 1016 Eutaw

15 OCT 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchial

Fundays (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Oct 30 192 4 (Address) 7639 Bun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-31-24

20 UNDERTAKER Dan'l Easton

ADDRESS 916 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91535

2/ D 91535

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Branch

(a) RESIDENCE NO. 2014 Bolton st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Chas. Martin

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Branch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Meeks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed OCT 31 1924, 19 ROBERT R. KRAUTLE, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1924, to Oct. 29, 1924, that I last saw her alive on Oct. 29, 19 24, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Richard Short, M. D.

10-29-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-31-24

20 UNDERTAKER Dunn & Easton

ADDRESS Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 91536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Barber

(a) RESIDENCE NO. 512 N. Pine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Riley Brown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Jenny Ralston

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-9, 1924, to 10-29, 1924, that I last saw her alive on 10-29, 1924 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Cystadenoma of Ovary (Right)

..... (duration) ..... yrs. 10 mos. (Hosting)

CONTRIBUTORY (Secondary) Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Davis, M. D.

10-30, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 10-31-24 19

20 UNDERTAKER David Easton — ADDRESS 916 E Pratt

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91537 — 1:0.760,0.031,0.815,0.060

+ 31 D 91537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 175 ST., 7 WARD) JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doosi L David Porter

(a) RESIDENCE NO. Turners Station, Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Templater Ost

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John A Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to Oct 29, 1924, that I last saw him alive on Oct 29, 1924, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

The primary cause of illness was acute tonsilitis meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis E. Martin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newport News Va — DATE OF BURIAL Oct 31 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Lig St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 90

City of BALTIMORE: (No. 606 Potomac Ave St., Brooklyn Ward)

2-FULL NAME William Robert Barrack

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

(a) Residence No. 606 Potomac Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Barrack

6-DATE OF BIRTH (month, day and year) Jan 31 1890

7-AGE. 34 yrs. 8 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Chocolate Products Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, William C. Barrack

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Middlesex Co Va

12-MAIDEN NAME OF MOTHER, Mary L. Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dorchester Co Md

14- (Informant) Mrs Margaret E Crockett (Sister)

(Address) 604 Potomac Ave

15- OCT 31 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). October 29 1924

17- I HEREBY CERTIFY, That I attended deceased from 10-18, 1924 to 10-29 1924

that I last saw h. alive on 10-29 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(1) Cardiac decompensation

(2) acute leukemia (suppression acute)

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Mitral disease

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical Symps.

(Signed) James Brown M. D.

, 19 (Address) 1319 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL, Nov 1 1924

20-UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Pauline Ashby.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91539

CERTIFICATE OF DEATH.

114

D 91539

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Peach alley ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Polline ashby

(Residence in Baltimore: No. 1025 Peach alley St.: 18 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 26 (Month) (Day), 1877 (Year)

7-AGE, 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Md

PARENTS

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Ashby

(Address) 1025 Peach alley

15- OCT 31 1924

Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct-26 1924 to Oct-28 1924, that I saw h[illegible] alive on Oct-28 1924 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Gastritis

..... (Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Life

..... (Duration) 6 yrs. 6 mos. ds.

(Signed) Thomas H. Brown M. D.

Oct. 28, 1924 (Address) 121 W Hamburg St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Zion Cem

DATE OF BURIAL, Nov 2, 1924

20-UNDERTAKER H. Lee Bromwell Son

ADDRESS 1000 Mount St

D 91540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91540

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2103 Smallwood St. WARD) 20

2-FULL NAME Frank Dettmann

(Residence in Baltimore: No. 2103 Smallwood St. St.: yrs. 50 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	married

6-DATE OF BIRTH, May (Month) 28 (Day), 1848 (Year)

7-AGE, 76 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Dettmann

(Address) 2103 Smallwood St.

Filed OCT 31 1924 191. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 29 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Oct. 30, 1924 (Address) 280 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov. 1, 1924

20-UNDERTAKER Josiah Effler — ADDRESS 1600 W. North Ave

Spec– 12-23-21–E.B.R.S.–400 Bks.

91541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 B 91541

1-PLACE OF DEATH

City of BALTIMORE: (No. 621 W Biddle St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Celia Gaskins

(a) Residence No. 621 W. Biddle St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 5-1922

7-AGE. 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None old

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. James Mc Donald

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Bettie Haskins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Bettie Satchel

(Address) 621 N Biddle St

15- Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/29/24

17- I HEREBY CERTIFY, That I attended deceased from October 4 1924 to Oct 29, 1924 that I last saw h. Ev alive on Oct 28 1924 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration) 3 yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 36 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

10/30 1924 (Signed) H. M. Card M. D.

(Address) 2005 d Hillen

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn C. DATE OF BURIAL. Oct 31, 1924

20-UNDERTAKER. J. H. V Brown Son ADDRESS 1014 W. Mont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

D 91542

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 D 91542

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1909 N. Regester ST.: 8 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frank Edelman

(Residence in Baltimore: No. 1909 N Regester St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If not the word): Single

6 DATE OF BIRTH: Nov 23, 1876 (Month) (Day) (Year)

7 AGE: 47 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Balto.

PARENTS

10 NAME OF FATHER: Thos Edelman

11 BIRTHPLACE OF FATHER (State or country): Balto

12 MAIDEN NAME OF MOTHER: Charlotta Rapley

13 BIRTHPLACE OF MOTHER (State or country): Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachel Edelman

(Address) 1909 N. Regester St

15 OCT 31 1924

ROBERT R. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 31, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1924, to Oct 31, 1924, that I saw him alive on Oct 30, 1924, and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Bright's

(Duration) yrs. mos. ds

Contributory (SECONDARY) Convulsions

(Duration) yrs. mos. ds.

(Signed) Wm D Corse M. D.

Oct 31, 1924 (Address) Fredonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Gen'l — DATE OF BURIAL: Nov 3 1924

20 UNDERTAKER: Walter L Kemp — ADDRESS: 604 E 28th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. John Thomas

D 91543

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 91543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Pierre ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas

(a) RESIDENCE No. 611 Pierre St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Thomas.

6 DATE OF BIRTH (month, day, and year) June 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 67

(b) General nature of industry, business, or establishment in which employed (or employer) Long Shoreman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Mary Thomas (Address) 611 Pierre St.

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

OCT 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept ....., 19 24, to Oct 30, 19 24, that I last saw h— alive on Oct 30, 19 24 and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Capilliary Bronchitis.
"not TB"

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Bronchial Asthma

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

19 (Signed) Bernard T. Smith, M. D.

Oct 31. 19 24 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Petus Cem.	Nov 3 1924
20 UNDERTAKER Mrs. P. C. Elliott	ADDRESS 1720 Ashland.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 91544 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 91544

CERTIFICATE OF DEATH. 51

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Jordon ST.: | | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Blaney

(a) RESIDENCE. NO. 913 Jordon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Blaney

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 57 Months If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driving coal wagon

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Sarah Blaney 913 Jordon

15 Filed NOV 1 - 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1924, to Oct 30, 1924

that I last saw him alive on Oct 29, 1924

and that death occurred, on the date stated above, at 1/2 noon

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Grant Forbutt, M. D.

10-31 1924 (Address) 354 N. Bdle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Nov 1 1924

20 UNDERTAKER: Sam'l R. Case & Son — ADDRESS: 1400 Mcalm

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91545

CERTIFICATE OF DEATH.

164 D 91545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Somerset ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie J. Stutz

(a) RESIDENCE NO. 1003 Somerset ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Not Known yrs. mos. ds. How long in U. S., if of foreign birth? Not Known yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Schneider

(Address) Lombard St.

OCT 31 1924

Filed ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28. 1924, to Oct. 29. 1924.

that I last saw her alive on Oct. 29. 1924;

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? unknown at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) J. J. Sebald, M. D.

, 19 (Address) 1011 Virginia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 1st 1924
20 UNDERTAKER	**ADDRESS**
Henry Horck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91546 ✓ 73 D 91546

1-PLACE OF DEATH D 91546 Registered No.....

City of BALTIMORE: (No. 1620 Ashland ave St., 17th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Giwinner

(a) Residence No. 1620 Ashland St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph H.

6-DATE OF BIRTH (month, day and year) May 26, 1869

7-AGE. 55 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Athome

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Charles N. Selvage

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Mary E. Schisler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14- (Informant) Jos. H. Giwinner

(Address) 1620 Ashland ave

15- OCT 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 1924 to Oct 30, 1924

that I last saw h.... alive on Oct 30, 1924

and that death occurred, on the date stated above, at 9.30A m.

The CAUSE OF DEATH* was as follows:

Acute Respiratory Paralysis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Asthenia - Multiples

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. C. Kerby M. D.

Oct 30, 1924 (Address) 1201 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL, Nov 3, 1924

20-UNDERTAKER Finkler & Finkler — ADDRESS 1739 E Eager st

Spec.—1-10-21—M&T—150M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16968 30 A 11

D 91547

100-001

CERTIFICATE OF DEATH.

D 91547

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Taylor

(a) RESIDENCE NO. St. Vincents Infant Asylum ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address)

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to Oct 30, 1924, that I last saw him alive on Oct 30, 1924, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho-

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. None ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Wm Jacobson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenslad

DATE OF BURIAL Oct 31 1924

20 UNDERTAKER Martin Funeral Home

ADDRESS 1819 W North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91548 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91548

CERTIFICATE OF DEATH.

REGISTERED No. 146

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Franklin Sq. Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera May Eader

(a) RESIDENCE No. 1307 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U.S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Eader

6 DATE OF BIRTH (month, day, and year) Nov 16. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) (37)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank B. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Kenemuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Raymond R. Eader

(Address) 1307 W. Fayette

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-1924

17 I HEREBY CERTIFY, That I attended deceased from 10-13- 1924, to 10-28- 1924, that I last saw her alive on 10-28- 1924, and that death occurred, on the date stated above, at 11 10 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Streptococcus Hemolyticus)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Pregnancy abortion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-13-24

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) N. J. Carr, M. D.

10/25, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Oct 31 1924

20 UNDERTAKER, John C. Hutchins ADDRESS 1301 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

74 D 91549

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 338- N- Bond St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clark Westley Brown

(a) Residence No. 338- N- Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~ Elizabeth Brown

6-DATE OF BIRTH (month, day and year) March 2, 1877

7-AGE, 47 yrs. 7 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

009

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk in store

(c) Name of employer Person Co.

9-BIRTHPLACE (city or town) (State or Country), Fredrick Co Md

PARENTS.

10-NAME OF FATHER, Samuel Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Fredrick Co Md

12-MAIDEN NAME OF MOTHER, Jemima Armstrong

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Elizabeth Brown

(Address) 338- N- Bond St

OCT 31 1924

Filed ..... 19.. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 28, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct 24, 19 24, to Oct 28, 19 24,

that I last saw him alive on Oct 28, 19 24,

and that death occurred, on the date stated above, at 6:9 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 yrs. 6 mos. 2 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Powers, M. D.

, 19 (Address) 1618 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Nov. 1, 1924.
20-UNDERTAKER, Mrs. Kate R. Williams	ADDRESS 322 E. Schroeder St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91550

1/18 D 91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Eastern Ave & Galloway

CITY OF BALTIMORE: (No. East Falls Ave, ST., 3 WARD)

REGISTERED NO.....

(If death occurred ... pital or institution ... NAME instead of ... number and fill out ...

2-FULL NAME Robert E. Smith

(a) RESIDENCE NO. 5/6 Gen. Schofield ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and ...

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	whit	Singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U S Government

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Texas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Texas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant E M Fenton
(Address) 700 E Chase st

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct

17 I HEREBY CERTIFY, That I took ... remains described above, held an Inquest (Inquest, autopsy ...) thereon and from the evidence obtained by said ... Inquest (autopsy or inquiry,) find that said deceased came t... on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Dro... fell from Boat ... East Falls Ave

(duration) ..... yr...

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mo...

(Signed) James M Fenton (Coroner.)

Oct 30 1924 (Address) 700 E Ch...

*State the Disease Causing Death, or in deaths from Vio... state (1) Means and Nature of Injury, and (2) whether ... Suicidal, or Homicidal. (See reverse side for additional space.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr... Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mo...

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lenoir N. C.

DAT...

20 UNDERTAKER Avl Linson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. 64 3½

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91551

CERTIFICATE OF DEATH.

129 D 91551

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ... ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennie Rubinstein
W. M. Ca.

(a) RESIDENCE No. Pratt & Linn ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 3 yrs. 6 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Rubinstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Gedalia Rubenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Joseph Rubenstein
(Address) 2123 W Northern

15 OCT 31 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1924, to Oct 31, 1924, that I last saw him alive on Oct 31, 1924, and that death occurred, on the date stated above, at 5 10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arthritis, Emphysema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab.

(Signed) Isidor I. Fox, M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Hebrew Cem

DATE OF BURIAL 11/2 1924

20 UNDERTAKER J. Ferguson Bro

ADDRESS 1127 E Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91552

CERTIFICATE OF DEATH.

1-001

161 D 91552

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maternity Hospital WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hicks

(a) RESIDENCE NO..... ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28/24

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Earl Brockton

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Anna Hicks

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Anna Hicks
(Address) [illegible]

15 OCT 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

1965

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-28, 1924, to 10-29, 1924, that I last saw him alive on 10-29, 1924, and that death occurred, on the date stated above, at 1.25 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: OCT 31 19

20 UNDERTAKER: Commissioner Health,

ADDRESS

Per Wm. E. WOODALL

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91553

CERTIFICATE OF DEATH.

162 D 91553

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 N. Gilmore ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Frisby

(Residence in Baltimore: No. 1138 N. Gilmore St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Oct 29 1924 (Month) (Day) 1 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 17 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph Frisby

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Bertie Smith

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed OCT 31 1924, 191... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1924, to Oct 30 1924, that I saw her alive on Oct 29 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

..... Asthenia .....

..... (Duration) 0 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prolonged labor

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Susanne R Bangs M. D.

10-30, 1924 (Address) 1702 Westwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 31 1924

Dept. of Health.

Per Wm. E. WOODALL

1904

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91554

CERTIFICATE OF DEATH.

90 D 91554

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 N. Calvert St. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith C. Mears

(a) Residence No. 805 N. Calvert St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Feb. 16, 1889

7-AGE. 35 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry W. Mears

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Emma J. Roney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant) Samuel R. Mears

(Address) 805 N. Calvert St.

15- OCT 31 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1924 to Oct 28 1924

that I last saw h[illegible] alive on Oct 28 1924

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Emma F. Mayer M. D

10/31 1924 (Address) The Esplanade

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	11/1, 1924
20-UNDERTAKER.	ADDRESS
H. W. Mears & Son	805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 91555

CERTIFICATE OF DEATH.

D 91555

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wawrzyniec Sasnowski

(a) Residence No. Mount Hope Retreat St., 28th Ward

(Usual place of abode)

Length of residence in city or town where death occurred since birth yrs. mos. ds. How long in U. S., if of foreign birth? Don't Know yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Sasnowski

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. About 66 or 76 (?) yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Brass Founder

(b) General nature of industry, business, or establishment in which employed (or employer). Brass work 010

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). (?) Poland

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). (?) Poland

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). (?) Poland

14-

(Informant) Records of Mt. Hope Retreat

(Address) Mt Hope Retreat Md

OCT 31 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 22nd 1924, to Oct 29th 1924, that I last saw him alive on Oct 28th 1924, and that death occurred, on the date stated above, at 12 30 noon m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebral Atheroma

abt (?) (Duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (Duration) 2 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Oct 29, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary Cemetery

DATE OF BURIAL. Nov 3rd 1924

20-UNDERTAKER. Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Women Home St., 19 Ward)

Registered No. 74-901

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Ridgway

(a) Residence No. 1400 W. Lexington St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, W H

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 16, 1842

7-AGE, 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Talbot Co Md

PARENTS.

10-NAME OF FATHER, William Tarbutton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Talbot Co

12-MAIDEN NAME OF MOTHER, Sarah Rice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Talbot Co Md

14- (Informant) Ella J Jones Matron

(Address) 1400 W Lexington

15- Robert P. Harrison, Registrar.

Burial Permit Clerk.

OCT 31 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 31/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 19 24, to Oct 31 19 24

that I last saw h alive on Oct 30 19 24

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T Woodward, M. D.

Oct 31 19 24 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Michaels Md	Nov 1 19 24
20-UNDERTAKER, George J Smith	ADDRESS 153 Hollins

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3304 E. Baltimore St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wagner

(a) Residence No. 3304 E. Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, Widowed, Widow or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Wagner

6-DATE OF BIRTH (month, day and year) Oct 11 1845

7-AGE 79 yrs. 2 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs. Emma L. Hooker

(Address) 3304 E. Baltimore

15-

OCT 31 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 29 1924

17- I HEREBY CERTIFY, That I attended deceased from 9-1- 1924 to 10-29 1924

that I last saw him alive on 10-29 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Dunn M. D.

, 19 (Address) 709 Mosher Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Nov 1, 1924
20-UNDERTAKER,	ADDRESS
Jos Jourdens Son	207 S. Pac

GT 3

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91558

CERTIFICATE OF DEATH.

3 D 91558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

2-FULL NAME Rose Wagner

(a) RESIDENCE NO. 611 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER A. Wagner

11 BIRTHPLACE OF FATHER (city or town) W. Va (State or country)

12 MAIDEN NAME OF MOTHER Jane Lough

13 BIRTHPLACE OF MOTHER (city or town) W. Va (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed 19 Robert P. Harrison Registrar

CT 3 1 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-27, 1924, to 10-29, 1924 that I last saw her alive on 10-29, 1924 and that death occurred, on the date stated above, at 10 40 p. m.

The CAUSE OF DEATH* was as follows:

C.N.S Syphilis (General Paresis)

(duration) yrs. 2 mos. (History)

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude G. Deuel, M. D.

10-30, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Oct 31, 1924

20 UNDERTAKER Edw. Levo ADDRESS 584 E. Lanvale St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91559

CERTIFICATE OF DEATH.

1350

1-PLACE OF DEATH

City of BALTIMORE: (No. Home for the Aged St. 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael Gavin

(a) Residence No. Little Sisters of the Poor St., Fulton Ward. Preston Sts.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) Unk —

7-AGE, 86 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary McHale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-

(Informant). Sisters Housekeeper

(Address) Little Sisters of the Poor

15-

Filed ..... 192.. Robert P. Bartram Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30/24

17- I HEREBY CERTIFY, That I attended deceased from No record, 19.., to ....., 19.....,

that I last saw h.. alive on Oct 26, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prostatitis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) debility of age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Oct (Signed) F. A. Warner, M. D.

31, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral	Nov. 1, 1924
20-UNDERTAKER.	**ADDRESS**
J. C. Windfield	914 Greenmount Ave

Burial Permit Clerk

OCT 31 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 N. Carey St., 16 Ward)

Registered No. 161-001 D 91560

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Torres Jr

(a) Residence No. 646 N Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 24th 1924

7-AGE. yrs. mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER Gilbert Torres

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER Fannie Walker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Mr Gilbert Torres Sr

(Address) 646 N Carey St

15- Filed OCT 31 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1924 to Oct 30 1924

that I last saw him alive on Oct 30 1924

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Intoxication

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Premature birth 7 mo. in utero

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) S B Hughes M. D

Oct 31, 1924 (Address) 1413 D. Hill Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Grove DATE OF BURIAL Oct 31 1924

20-UNDERTAKER. Samuel E Wright ADDRESS 364 N Carey

OCT 31 1924

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91561

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 S. Broadway St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A. Grooms

(a) Residence No. 528 S. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1864

7-AGE. 60 yrs. mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER Nathan Grooms

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER Elizabeth Dorsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) James Grooms

(Address) 528 S. Broadway

15- Filed 19 Registrar

OCT 31 1924 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-30-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1924 to Oct 30 1924

that I last saw h[illegible] alive on Oct 29 1924

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) J. D. Douglas M. D

10/30 19 24 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount DATE OF BURIAL. Nov 3 1924

UNDERTAKER. Clarence E. Wright ADDRESS 364 W. Mary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S additional statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91562

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mersey Hospital ST., W WARD)

2-FULL NAME Emerson Y. Davenport

(a) RESIDENCE No. Cockeysville ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colr	Don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Talbot Davenport

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant W. E. Chatman
(Address) Phoenix Md

15 Filed OCT 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Internal Injuries

(Duration) yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Lowndes, M. D.
(Coroner.)

10-31, 1924 (Address) 10 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dept Cemetery DATE OF BURIAL Nov 2 1924

UNDERTAKER Hamme & Wight ADDRESS 364 Mcary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91563

CERTIFICATE OF DEATH.

101-06 B 91563

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Harford ave ST., 9 WARD)

2-FULL NAME Royston . T. Anderson

(a) RESIDENCE NO. 1719 Harford ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 16 /22

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
2	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bessie Swaby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert . T. Anderson
(Address) 1719 Harford ave

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

OCT 31 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 19 2X, to Oct. 30, 19 2X, that I last saw h... alive on Oct. 30, 19 2X, and that death occurred, on the date stated above, at X P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Lee Hagner, M. D.

12/1, 192X (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Nov. 1 1924

20 UNDERTAKER George . J. Ruth

ADDRESS 1735 Harford ave

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTICE TO PHYSICIANS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91564

133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Washington ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John V. Eisele

(a) RESIDENCE No. 215 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Borg

6 DATE OF BIRTH (month, day, and year) Sept 11 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Annie Eisele

(Address)

15 Filed NOV 1 - 1924 . 19 Robert P. Mattfeldt, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17

I HEREBY CERTIFY, That I attended deceased from year 1 . 1915 . to Oct 31 . 1924 .

that I last saw him alive on Oct 26 . 1924 .

and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Cystitis

(Pulmonary Edema)

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Senile degeneration

unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

. 19 (Address) 1131 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov. 3 19 24

20 UNDERTAKER Fr. J. Herr — ADDRESS 156 N. Eutaw

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91565

CERTIFICATE OF DEATH.

57 D 91565

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1528 Pilmer ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Hammond

(a) RESIDENCE NO. 1528 Pilmer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hammond

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Ethel Shaw

(Address) 1518 Wilmot Ave

15 Filed NOV 1 - 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-1924

17

I HEREBY CERTIFY, That I attended deceased from 10-28-24, 19..., to 10-30-, 19 24.

that I last saw her alive on " ", 19...

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) debility, Rheumatism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Landey, M. D.

10-31 1924 (Address) 524 Dallas.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-1-24
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Lemmon

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91566

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 91566

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2207 N. Calvert St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Chapman Washington

(a) Residence No. 2207 N Calvert St., ... Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 83 yrs. ? mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) About 1841

7-AGE, About 83 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town)... Baltimore

(State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, James H Washington

11-BIRTHPLACE OF FATHER (city or town)..... Balto.

(State or Country), md

12-MAIDEN NAME OF MOTHER Julia Ann Chapman

13-BIRTHPLACE OF MOTHER (city or town) Balto.

(State or Country) md.

14- (Informant) Miss Eliz. Crookshanks

(Address)..... 2207 N Calvert St

15- Filed NOV 1 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1918, to Oct 30, 1924, that I last saw h.. alive on Oct 30, 1924, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Valvular heart disease, 6

Chronic bronchitis

about 6 years

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1/2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knipp, M. D.

Oct 30, 1924 (Address) 1002 N Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Cemetery

DATE OF BURIAL, Nov 1, 1924

20-UNDERTAKER Stewart & Bowen Company (William F. Wooden, Successor)

ADDRESS 108 W. North Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be understood. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 91567

CERTIFICATE OF DEATH

Time of burial changed to Nov 4/24

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 805 Hamilton Terrace St.; 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Allen Thompson

(Residence in Baltimore: No. 805 Hamilton Terrace St.; 7 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6-DATE OF BIRTH About - - , 1854 (Month) (Day) (Year)

7-AGE About 70 yrs. - mos. - ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cutlery Business
(b) General nature of industry, business, or establishment in which employed (or employer): (Self)

9-BIRTHPLACE (State or country) Thomasville Ga.

PARENTS

10-NAME OF FATHER Amon H. Thompson

11-BIRTHPLACE OF FATHER (State or country) Georgia

12-MAIDEN NAME OF MOTHER Nancy Spear

13-BIRTHPLACE OF MOTHER (State or country) Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Jesse F. Thompson (Brother)
(Address) Atlanta Ga.

15- Robert F. Harrison, 191
REGISTRAR Burial Permit Clerk

NOV 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct 28, 1924 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 6, 1924, to Oct 28 1924, that I saw h-m alive on Oct 28, 1924, and that death occurred, on the date stated above, at 1145 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 4 yrs. mos. ds

Contributory (SECONDARY) Cold

(Duration) yrs. mos. 22 ds.

(Signed) R. L. Lipsitz M.D.

Oct 31, 1924 (Address) Wentworth apts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Nov 4, 1924.

20-UNDERTAKER: Stewart & Co.

ADDRESS: 108 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 91568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1179

D 91568

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME Adel D Gladden

(a) RESIDENCE No. 408 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred x yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or ~~divorced~~
~~HUSBAND of~~ WIFE of Ella J Miller

6 DATE OF BIRTH (month, day, and year) July 11 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) House Building
(c) Name of employer

9 BIRTHPLACE (city or town) Jarrettsville
(State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Gladden

11 BIRTHPLACE OF FATHER (city or town) Rocks
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marietta Durham

13 BIRTHPLACE OF MOTHER (city or town) Georgetown
(State or country) Maryland

14 Informant Mrs E J Kurtz (Sister)
(Address) Jarrettsville Md

15 Filed ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31- 1924

17
I HEREBY CERTIFY, That I attended deceased from 10-30- 1924, to 10-31- 1924, that I last saw him alive on 10-31- 1924, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene Appendicitis
General Peritonitis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 10-30-24

Was there an autopsy? no

What test confirmed diagnosis? Op. findings

(Signed) H. J. Parr, M. D.

10/31/1924 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Calvary Cem. Jarrettsville Md	Nov 3 1924
20 UNDERTAKER	**ADDRESS**
E J Kurtz & Son	Jarrettsville Md

NOV 1 - 1924

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91569

CERTIFICATE OF DEATH.

3/4 D 91569

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 E. Biddle ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Jones.

(a) RESIDENCE No. 2003 E. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada V Jones.

6 DATE OF BIRTH (month, day, and year) Aug. 3. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	56	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Meeske Construct Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary C Gatchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ada V. Jones

(Address) 2003 E Biddle St

15 Robert P. Harrison,

Registrar

Burial Permit Clerk.

NOV 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Oct 31, 1924, that I last saw him alive on Oct 30, 1924, and that death occurred, on the date stated above, at 11.9. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 11 4 ds.

18 Where was disease contracted if not at place of death? Daytona Florida

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos A Stevens, M. D.

10/31. 1924 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 11/3 1924

20 UNDERTAKER George J Ruth PERAH

ADDRESS 1735 Harford Ave

MARYLAND REGISTRATION BLANK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 91570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-B 91570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. on Street at Sojourner Douglass St., 4 WARD)

2-FULL NAME Chas. F. Taylor

(a) RESIDENCE NO. 664 W. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb-10-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Mrs Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Carin Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Elsie Taylor
(Address) 1419 Dallas St

NOV 1 - 1924

Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coma Hosty Cerbral apoplexy
a few hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) W R Gerwell, M. D. (Coroner.)

10-31, 1924 (Address) 113 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: Nov 1 1924

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.P.S.–400 Bks.

D 91571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 816 Washington Blvd. 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. A. Mason

(a) Residence No. 816 Washington Blvd. Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah Virginia Mason

6-DATE OF BIRTH (month, day and year) April 4-1847

7-AGE. 77 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)..... B & O. R. R. 62

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Philip Mason

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Not given

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto

14- (Informant) Florence M. Mason

(Address) 816 Wash. Boulevard

15- Filed NOV 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 29-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Oct 29 1924 that I last saw h[illegible] alive on Oct 25 1924, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wiley Hoag M. D.

Oct 30, 1924 (Address) 729 Cath. Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Olivet — DATE OF BURIAL, Nov 1, 1924

20-UNDERTAKER, F. A. Kramer & Son — ADDRESS 103 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 91572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91572

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1719 E. Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin C. Wilburn

(a) Residence No. 1719 E. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eva M. Wilburn

6-DATE OF BIRTH (month, day and year) Sept 29-1876

7-AGE. 48 yrs. 1 mos. 1 ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Special Officer

(b) General nature of Industry, business, or establishment in which employed (or employer) Balto Fire Dept

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Walter Wilburn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Eva M. Wilburn

(Address) 1719 E. Charles St.

15- Filed NOV 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 31-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 19 24 to Oct 31 19 24 that I last saw h[illegible] alive on Oct 30 19 24 and that death occurred, on the date stated above, at 2.30 A. m. The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. Ed Magness M. D

10,31 1924 (Address) 1206 E. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. Nov 2..., 1924

20-UNDERTAKER, T. A. Pearce & Son — ADDRESS 103 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91573

D 91573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 Bradley Av ST. 17 WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucille Grooms

(a) RESIDENCE NO. 745 Bradley Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1924 (guess)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Elmer Grooms

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Esther Scott

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Eugene Watkins
(Address) 153 Pierce St

15 Filed NOV 1 1924 192 Robert F. Carlson
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

W whooping cough.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Oct 31 1924 (Address) 802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-1-24 192

20 UNDERTAKER Dan'l Easton

ADDRESS 916 Gilmor

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91574

CERTIFICATE OF DEATH.

49 D 91574

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blazya Czaplan a Chopka

(a) RESIDENCE No. 838 S. Bond ST., WARD

(Usual place of abode) Unknow

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Andy Czoplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Municipal Hospital Records (Address)

15 Filed NOV 1 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 1924, to 10-30, 1924, that I last saw h.. alive on 10-30, 1924 and that death occurred, on the date stated above, at 11 5-5 a. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma with extensive Metastases

(duration) yrs. 8 mos. (History)

CONTRIBUTORY (Secondary) Mrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude A. Grace, M. D.

10-30 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Nov 3	1924
20 UNDERTAKER	ADDRESS
John McWeber	803 Bank St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91575

HEALTH DEPARTMENT—CITY OF BALTIMORE

1610 91575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp St., 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Godomski

(a) Residence No. 2321 Essex St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 30, 1924

7-AGE, Premature yrs. mos. ds.

If LESS than 1 day, hrs. or 15 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto. Md (State or Country).

PARENTS.

10-NAME OF FATHER. Wladyslaw Godomski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER. Victoria Klek

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mrs. Victorya Godomski

(Address) 2321 Essex St

15- Filed NOV 1 1924 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....

that I last saw him alive on Oct 30 1924

and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Immature Delivery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P S & S

(Signed) John J Kluger M. D.

19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL. Nov 1 1924

20-UNDERTAKER. John M Weber

ADDRESS 1803 Bank St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4507 Maine Ave ST., 27 WARD)

REGISTERED NO. 91576

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willanna Wesley

(a) RESIDENCE No. 4507 Maine Ave (Laurayille) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	whote	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Wesley

6 DATE OF BIRTH (month, day, and year) Sept 8/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nancy Myer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Wesley (Address) 4507 Maine Ave

15 Filed NOV 1 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Found dead In bed)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Walker, M. D. (Coroner.)

Nov 1/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 1 1924

20 UNDERTAKER Chenoweth & Son ADDRESS 3615 Chestnut ave

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91577

CERTIFICATE OF DEATH.

117 D 91577

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hospital ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline Ferrer

(a) RESIDENCE No. 2744 Riggs Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER David Clements

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nancy E. Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Charles D. Ferrer (Address) 717 Washington Blvd

15 Filed NOV 1 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1924, to Oct 31, 1924, that I last saw her alive on Oct 31, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendix with Spreading Peritonitis

(duration) ... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct 27'24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. W. Kratz, M. D.

Oct 31 1924 (Address) Md. Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 11/3 1924

20 UNDERTAKER Clarence A. Tempest — ADDRESS 776 Hamburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91578

CERTIFICATE OF DEATH.

16 D 91578

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., WARD)

2-FULL NAME Baby Namiko Sugiyama

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: ~~White~~

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 28. 24

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Shigetomi Sugiyama

11 BIRTHPLACE OF FATHER (city or town) (State or country): Japan

12 MAIDEN NAME OF MOTHER Yoko Tawano

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Japan

14 Informant
(Address)

15 Filed NOV 1 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1924, to Oct 30, 1924, that I last saw h[illegible] alive on Oct 30, 7, 1924, and that death occurred, on the date stated above, at 11.00 p.m.

The CAUSE OF DEATH* was as follows:
Intra Cranial haemorrhage
(birth injury)
(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 30, 1924

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

10/31, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: Oct 31 1924

20 UNDERTAKER — ADDRESS

Dept. of Health.
Per Wm. E. Woodall

MARGIN RESERVED FOR BINDING. Digitized by Google

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 91579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-08 91579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 13 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion Turner

(a) RESIDENCE No. 4030 RolandAve ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 1st 1923 /1922/

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Samuel Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital (Address)

15 Filed NOV 1 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pachymenigitis-Hemorrhagica interna

(Autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Cook (Coroner.), M. D.

Oct 29/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Chas. Schleicher Health

ADDRESS

P.906

MARGIN RESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OPERATION is very important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91580

CERTIFICATE OF DEATH.

74 D 91580

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 W Baltimore St. ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip J Stevens

(a) RESIDENCE NO. 2516 W Baltimore ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G Stevens

6 DATE OF BIRTH (month, day, and year) Jun 26, 1892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rector

9 BIRTHPLACE (city or town) (State or country) Phila. Pa

PARENTS

10 NAME OF FATHER John Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary J Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa

14 Informant Mary G Stevens (Address)

15 Filed NOV 1 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to Oct 30, 1924,

that I last saw him alive on Oct 30, 1924,

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Nephritis sub-acute

(duration) yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edw V. Coolahan, M. D.

, 19 (Address) Edward V. Coolahan 64 E Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov 3 1924

20 UNDERTAKER John F Fields — ADDRESS 1200 N Fremont

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91581

CERTIFICATE OF DEATH.

100-91 ✓ 91581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Austin

(a) RESIDENCE NO. 630 N. Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) C&O

(c) Name of employer

9 BIRTHPLACE (city or town) West Indies
(State or country)

PARENTS

10 NAME OF FATHER ?.

11 BIRTHPLACE OF FATHER (city or town) W. Indies
(State or country)

12 MAIDEN NAME OF MOTHER ?.

13 BIRTHPLACE OF MOTHER (city or town) W. Indies
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 NOV 1 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 28 1924

17 I HEREBY CERTIFY, That I attended deceased from 9 - 25, 1924 to 10 - 28, 1924

that I last saw him alive on 10 - 28, 1924

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, General + Cerebral Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Heaver, M. D.

10-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 2 1924
20 UNDERTAKER	ADDRESS
Jos. T. H. Rochester	1403 Jefferson St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3D 91582

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 E. 20th. St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Russell Handgarter Jr.

(a) Residence No. 700 E. Twentieth St. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 16th. 1924

7-AGE. ..... yrs. 15 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. J. Russell Handgarter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto.

12-MAIDEN NAME OF MOTHER. Margaret M. Lannon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto.

14-Informant. J. Russell Handgarter

(Address) 700 E. 20th. St.

15-Filed NOV 1 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 31 1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 23 1924 to Oct 31 1924 that I last saw h[illegible] alive on Oct 31 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Embolism of Lungs

(Duration) ..... yrs. ..... mos. 3 hrs ds.

CONTRIBUTORY (Secondary) Influenza of Heart

(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Thompson M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov. 1 1924

20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 91583

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Guilford Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Brotman

(a) Residence No. 1118 Guilford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Max Brotman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER Abraham Seidler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Shana —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Max Brotman

(Address) 1118 Guilford Ave

15- Filed NOV 2 - 1924 ROBERT R. KRAUSE Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/31/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1922 to Oct 31 1924

that I last saw h. alive on Oct 31 1924

and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer. Cyst of ovary abdomen (Duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Peritonitis

(Duration) 1 yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1923

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) W. E. Norris M. D.

Oct 31 1924 (Address) 1220 Maryland

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Reken Washington Co. DATE OF BURIAL. 11/2 1924

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 91584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Cohen

(a) RESIDENCE No. 657½ W. Lexington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	—	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 NOV 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept-16, 1924, to Oct 31, 1924.

that I last saw him alive on Oct-31, 1924

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Oesophageal [redacted] carcinoma

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic. autopsy & Lab.

(Signed) Isidor D. Jury, M. D.

Oct. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. DATE OF BURIAL 11/2 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91585

CERTIFICATE OF DEATH.

X113 D 91585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Hollins ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Catherine Ritenour

(a) RESIDENCE No. 2123 Hollins St ST., ... WARD Ellicott City

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): January 1, 1924

7 AGE: Years # 0 Months 3 Days 30

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicott City Maryland

PARENTS

10 NAME OF FATHER: Oscar W. Ritenour

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Grace L. Covey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Oscar W. Ritenour

(Address) 2123 Hollins St City

15 Filed NOV 2 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct. 31 1924

I HEREBY CERTIFY, That I attended deceased from Oct 29, 1924, to Oct 31, 1924

that I last saw h[illegible] alive on Oct 31, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Asc Pulm Oedema

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Auto Intoxication

Palmonary Tuberculosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W S Dudley, M. D.

Nov 1, 192[illegible] (Address) 33 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Johns Cem. | DATE OF BURIAL: Nov. 2 1924

20 UNDERTAKER: Easton Sons | ADDRESS: Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec- 12-23-21—E.B.R.S.—400 Bks.

91586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 91586

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 955 N. Gay St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Eisenberg

(a) Residence No. 955 N. Gay St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sofie Eisenberg

6-DATE OF BIRTH (month, day and year) Unk

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Louis Eisenberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Esther

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1429 E. Balto St.

15-

Filed NOV 2 - 1924 ROBERT R. RIVERS Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/1/24

17- I HEREBY CERTIFY, That I attended deceased from June 17, 1924 to Oct 23 1924

that I last saw h— alive on Oct. 23, 1924

and that death occurred, on the date stated above, at 4½ m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Hepatic Flexure about 6 months

(Duration) yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Xray

(Signed) Theo. H. Morrison M. D.

, 19 (Address) 1013 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pikesville Woodlawn	11/4 19 24
20-UNDERTAKER,	ADDRESS
Jack Lewis	1429 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 91587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91587

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 620 N Potomac ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Gieseler

(a) RESIDENCE No. 626 N. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~: Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of The Late John Gieseler

6 DATE OF BIRTH (month, day, and year) Jan 29 1851

7 AGE: Years 73 | Months 9 | Days 7 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Gottlieb Blankner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma Brinkmann

(Address) 620 N. Potomac St

15 Filed NOV 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1924

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1924, to Nov 1, 1924, that I last saw her alive on Nov 1, 1924, and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchо-Pneumonia (4 days)

{ Arterial Hypertension —
{ Arterial Sclerosis.

(duration) 2 yrs. mos

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

Cer. Bright's (duration) 2 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic exam —

(Signed) Louis H. Krumrein, M. D.

, 19 (Address) 722 N. Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 4 1924

20 UNDERTAKER: Jas E. Miller & Son — ADDRESS: 2334 Jeffer 24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91588

CERTIFICATE OF DEATH.

101 D 91588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 McElderry ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Babera Jones

(a) RESIDENCE NO. 2407 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Christian Jones

6 DATE OF BIRTH (month, day, and year) Dec 29-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Seibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kath Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Gertrude Riedel

(Address) 2407 McElderry St

15 NOV 2 - 1924 19 HUBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH Oct 30 /2

16 DATE OF DEATH (month, day, and year) Oct 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct-27 1924, to Oct 30- 1924

that I last saw her alive on Oct 29- 24

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

La Grippe en Pneumonia

(duration) yrs. mos 3 1/2 ds.

CONTRIBUTORY (Secondary) Cortex paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 125 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Germans United Evangelical	Nov 3 1924

20 UNDERTAKER ADDRESS

Chas C. Miller & Son 2334 Jeff

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91589

CERTIFICATE OF DEATH.

16 129 D 91589

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2747 Rainer ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E. Jolly

(a) RESIDENCE. No. 2747 Rainer ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Florence E Jolly

6 DATE OF BIRTH (month, day, and year) April 19-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt Lucas Bros

(b) General nature of industry, business, or establishment in which employed (or employer) Printers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George C Jolly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Harryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Florence E Jolly (Address) 2747 Rainer ave

15 Filed NOV 2 - 1924, 19 . ROBERT R. KNAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31- 19 24

17 I HEREBY CERTIFY, That I attended deceased from June 9- , 1924, to Oct. 31- , 1924, that I last saw h[illegible] alive on Oct 31 - , 1924, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis & Myocarditis -

Probably a year or more
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General dropsy & Uremia

about (duration) 3 wks yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Carlton A. Bell, M. D.

Nov. 1924 (Address) 2219 St Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Nov 3. 1924
20 UNDERTAKER Tom Cook	ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stoc—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91590

CERTIFICATE OF DEATH.

+4 D 91590

1-PLACE OF DEATH St Josephs Hospital — Registered No.

City of BALTIMORE: (No. ..... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cheman

(a) Residence No. 2016 N. Calvert St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Florence T. Cheman

6-DATE OF BIRTH (month, day and year) Feb. 18 1875

7-AGE.	If LESS than 1 day,
49 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Advertising
(b) General nature of industry, business, or establishment in which employed (or employer) 886
(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Frederick Cheman

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Germany

12-MAIDEN NAME OF MOTHER Frederica Cheman

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Maryland

14-
(Informant) Florence T. Cheman
(Address) 2016 N. Calvert St.

15-
Filed NOV 2 - 1924 MURRAY S. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 1, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 1924 to Nov 1st 1924 that I last saw h[im] alive on Nov 1 1924 and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder.

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exam Physical

(Signed) G B Eyket M. D.

, 19 (Address) St Josephs Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Gardens	11 3 24, 19....

20-UNDERTAKER.	ADDRESS
H. E. Hughes	1st N. Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mrs. Pyne — 1700 Linden Ave

D 91591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

D 91591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Hamilton Terrace ST. 11 WARD)

2-FULL NAME Marie Emma Pyne

(a) RESIDENCE NO. 52 Hamilton Terrace ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B. Pyne

6 DATE OF BIRTH (month, day, and year): Oct 27 1879

7 AGE: Years 70 Months Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind

PARENTS

10 NAME OF FATHER: John Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: John B. Pyne

(Address): 52 Hamilton Terrace

15 NOV 2 - 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 20th, 1924, to Oct 31st, 1924,

that I last saw her alive on Oct 31st, 1924,

and that death occurred, on the date stated above, at 1-30 a m.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) William Mendenhall, M. D.

, 19 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Linden Park — DATE OF BURIAL: Nov 3 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

Eunice Lupton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91592

CERTIFICATE OF DEATH.

D 91592

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

2-FULL NAME Mrs Silas Lupton (Eunice) Eunice Lupton

(a) RESIDENCE NO. Winchester, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Silas Lupton

6 DATE OF BIRTH (month, day, and year) June 6 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thomas Hempstead

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Lottie Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Donald Lee De Yoe

(Address) Winchester Va

NOV 2 - 1924

ROBERT H. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1924, to Nov 7, 1924,

that I last saw h.. alive on Nov. 7, 1924,

and that death occurred, on the date stated above, at 8.50 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (left).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Emphysema & Thoracotomy

Lymphatic Leukemia (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-18-24

Was there an autopsy? No Evidence of Emphysema

What test confirmed diagnosis?

(Signed) A Austin Pearre, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va — DATE OF BURIAL 11-3 1924

20 UNDERTAKER Henry W Jenkins Sons — ADDRESS Orchard & McCulloch

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

175-778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91593

CERTIFICATE OF DEATH.

X 49 D 91593

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Aurora De Perez

(a) RESIDENCE NO. Havana Cuba ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Cuba

PARENTS

10 NAME OF FATHER Guillermo

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Venezuela

12 MAIDEN NAME OF MOTHER Boccardo

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Brazil

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 3 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1924, to Nov 1 -, 1924, that I last saw her alive on Nov 1 -, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Brain Tumor Malignant

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Cuba

Did an operation precede death? Yes Date of Nov. 1, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologic Exam

(Signed) Warfield M. Firor M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore MD

DATE OF BURIAL Nov 3 1924

20 UNDERTAKER Joseph Ahrens

ADDRESS 2216 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

183 D 91594

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of strect and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 22 WARD)

2-FULL NAME Anthony C Ruhl-

(a) RESIDENCE NO 42 S w Conway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker-
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Frederick Ruhl-

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Seitz

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs G Ruhl-
(Address) 42 S w Conway

NOV 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abscess in brain

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Accidentally shot by rifle

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gorman, M. D.
(Coroner.)

Nov 2, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HANCOCK MD

DATE OF BURIAL Nov 5 1924

20 UNDERTAKER Jos JOERDENS + SON

ADDRESS 217 S. Paca St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91595

Registered No. 1291

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 S. Carlton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Smith

(a) Residence No. 12 S. Carlton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor work

(b) General nature of industry, business, or establishment in which employed (or employer): 440

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Celia Francis

(Address) 836 Columbia Ave

15- NOV 3 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 31st 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 19 24 to Oct 31 19 24, that I last saw him alive on Oct 30 19 24, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cor Sclerosis

Mitral & Aortic Regurg

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Bernard H. Tom, M. D.

11/1, 19 24 (Address) 4 Hollins

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Cathedral Cem	Nov 3rd, 19 24
20-UNDERTAKER. John J. Gegner & Son	ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 91596 — 175754 — 57 — D 91596

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Emma Parolla

(a) RESIDENCE No. 9E. Chase St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 47 | Months | Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ?

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 3 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1924, to Oct 30, 1924, that I last saw h.. alive on Oct 30, 1924, and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Sequence of 1st post

Diabetic Sequence

(duration) yrs. 6 mos 9 ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis E. Martin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Burial — DATE OF BURIAL: 11/3/24

20 UNDERTAKER: Jesse H. Boddie — ADDRESS 1136 E. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 47 D 91597

Registered No.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Avenue St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Jackson.

(a) Residence No. 1622 Druid Hill Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Black.

5-Single, Married, Widowed or Divorced (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859.

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) 10

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Hospital Records

(Address) Bay View Hospital

NOV 3 - 1924

ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 2 1924

I HEREBY CERTIFY, That I attended deceased from Sept. 24 1924 to Nov 2, 1924

that I last saw h. alive on Nov 2 1924,

and that death occurred, on the date stated above, at 2 10 m.

The CAUSE OF DEATH* was as follows:

Ex Tumor Carcinoma of the Breast with metastases

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia, (Duration) yrs. mos. 2 ds.

15-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-24-24

Was there an autopsy?

What test confirmed diagnosis? Clinical Lab. Test

(Signed) Jas. O. Clark, M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL. Nov 3, 1924

20-UNDERTAKER. John H. Toadvine ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91598

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 91598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 828 Warner St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Carter

(a) Residence No. 828 Warner St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct- 26-1912

7-AGE. 12 yrs. — mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William D Carter

11-BIRTHPLACE OF FATHER (city or town), Northumberland (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Estelle Carter

13-BIRTHPLACE OF MOTHER (city or town), Baltimore (State or Country) Maryland

11- (Informant) William D Carter

(Address) 828 Warner

15- Filed NOV 3 - 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct- 30-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1924 to Oct 30 1924 that I last saw her alive on Oct 30, 1924 and that death occurred, on the date stated above, at 4 P.M. The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis and Tuberculosis of Spine

(Duration) 1 yrs. — mos. — ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Johns Hopkins.

(Signed) Dunn Trumbull, M. D.

10/31, 1924 (Address) 1222 Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL. Nov 3 1924

20-UNDERTAKER, John H. Soader — ADDRESS 1027 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

83 D 91599

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2139 E. Oliver St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Rice

(a) Residence No. 2139 E. Oliver St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Rice

6-DATE OF BIRTH (month, day and year): Feb. 11, 1846

7-AGE: 78 yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engineer & Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER: George Rice

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Effie Miles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14-(Informant): Joseph Rice

(Address): 2139 Oliver

NOV 3 - 1924

ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1924 to Nov 1, 1924, that I last saw h.. alive on Nov 1 of 1924 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Softening of Brain due to Arteriosclerosis.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. S. Watson M. D.

Nov 1, 1924 (Address) 2128 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	Nov. 4, 1924
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91600

CERTIFICATE OF DEATH.

24-001

D 91600

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Madison Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Catherine Borneman

(a) RESIDENCE No. 1918 Madison Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H. Borneman

6 DATE OF BIRTH (month, day, and year) Mar. 3 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Dedk Kaltenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Applegate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.

14 Informant Mrs Matilda Eaton (Address) 1918 madison ave.

15 Filed NOV 3 - 1924 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. C. T. Hennessey, M. D. (Coroner.)

Nov 1, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Nov 3 1924
20 UNDERTAKER Wm Tickner & Sons	ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91601

90

REGISTERED NO. D 91601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 E Eager ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen O'Connor

(a) RESIDENCE No. 1639 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? Lifes yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Laurence M. O'Connor

6 DATE OF BIRTH (month, day, and year) March 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	59	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sutherville . Md.

PARENTS

10 NAME OF FATHER Thomas Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary E. Connor

(Address) 1639 E Eager St.

Filed NOV 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 ..., 19 24, to Nov 1 ..., 19 24,

that I last saw h alive on Nov 1 ..., 19 24

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Acute Diffuse Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardio Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Lee Rountree, M. D.

11-2-24 (Address) 600 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 4 1924
20 UNDERTAKER	ADDRESS
Henry Storck Son	130 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91602

CERTIFICATE OF DEATH.

129 D 91602

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Rutland ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Catherine Murphy

(a) RESIDENCE NO. 1511 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Patrick F. Murphy

6 DATE OF BIRTH (month, day, and year) Not stated

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER James Kearney

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Mallow

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant M. Patrick F. Murphy

(Address) 1511 Rutland Ave

NOV 3 - 1924 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1924, to Oct 31st, 1924, that I last saw h[illegible] alive on Oct 31st, 1924, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Nephritis

Cardiac Dilitation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) William Messick, M. D.

(Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery (Govans.)	Nov. 5th 1924
20 UNDERTAKER Henry Hoerth Son	ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 91603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Southern Hospital & Home. REGISTERED No. C 52

CITY OF BALTIMORE: (No. 2520 Greenmount Ave. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Diffendeffer Brengle

(Residence in Baltimore: No. Southern Hospital & Home St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feby 11, 1835
(Month) (Day) (Year)

7-AGE, 89 yrs. 8 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Dr Michael Diffendeffer

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Salome Decker

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. G. Diffendeffer (niece)

(Address) Ruxton Md.

NOV 3 - 1924

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 31, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 28 1924 to Oct. 31 1924, that I saw h[er] alive on Oct. 31 1924, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) yrs. 2 mos. — ds.

(Signed) Dudley P. Bowe M. D.

Nov. 1, 1924 (Address) 904 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 89 yrs. 7 mos. 20 ds.

Where was disease contracted, if not at place of death? ? ? ? ? ? ? ?

Former or usual residence Southern Hospital

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, Nov 3, 1924

20-UNDERTAKER STEWART & POWER COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

Domenic Rundo

D 17538

D 17504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 91604

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

2-FULL NAME Domenic Rendo

(a) RESIDENCE NO. 54 Vincents ST., Angleson WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Anthony ? Rundo

11 BIRTHPLACE OF FATHER (city or town) ? Italy
(State or country)

12 MAIDEN NAME OF MOTHER Anna Mirabbi

13 BIRTHPLACE OF MOTHER (city or town) ? Italy
(State or country)

14 Informant Rendo
(Address)

15 Filed ..... 19 ROBERT R. KRAUTER,
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1924, to Nov 1 - 1924, that I last saw him alive on Nov 1 - 1924, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Acute laryngitis
(streptococcus hemolyticus)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents	11/3/24 19
20 UNDERTAKER Frank V. Pipitone	ADDRESS 1800 E. 32nd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91605

CERTIFICATE OF DEATH.

16-001

16 D 91605

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 405 N. Fremont Ave. Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Baby Chapman

(a) Residence No. 405 N. Fremont Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, black

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10/30/24

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 4 hrs. 40 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Wm. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Emma Collins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Emma Chapman

(Address) 405 N. Fremont Ave.

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-30-24

17- I HEREBY CERTIFY, That I attended deceased from 10-30, 1924, to 10-30, 1924, that I last saw him alive on 10-30, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

.....(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) M. Alexander Novey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL Nov 2, 1924

20-UNDERTAKER, Samuel D. Smaky ADDRESS 1078 Baddeck St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91606

CERTIFICATE OF DEATH.

X 16 001 D 91606

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Porter

(a) RESIDENCE No. Middle River Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Oct 18/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middle River Md.

PARENTS

10 NAME OF FATHER Simon Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Pauline Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Simon Porter
(Address) Middle River Md.

15 Filed NOV 3 1924, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(Ductus Arteriosus patent, autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Rollins, M. D.
(Coroner.)

Nov 3/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rutherdal Cem	Nov 3 1924
20 UNDERTAKER	ADDRESS
Samuel Hensley	Middle

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91607

REGISTERED NO. 129 D 91607

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME John Cartwright

(a) RESIDENCE No. 550 Mc Madden St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MC

PARENTS

10 NAME OF FATHER David Cartwright

11 BIRTHPLACE OF FATHER (city or town) (State or country) MC

12 MAIDEN NAME OF MOTHER Roda Grandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MC

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 3 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Oct 30, 1924, that I last saw him alive on Oct 30, 1924, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic glomerular Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Trevor Dwen, M. B.

Nov 5 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Nov 4 1924

20 UNDERTAKER Samuel Stransky ADDRESS 532 Madison

Spec—12-23-21—E.B.R.S.—400 Bks.

Clifford

D 91608

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-001

118 D 91608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. Katherine L. Clifford

(a) Residence No. Forrest Ave Morrell Park Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Clifford

6-DATE OF BIRTH (month, day and year) Dec. 9 1863

7-AGE. 61 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER Peter Rhinelandt

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country) Md.

12-MAIDEN NAME OF MOTHER Augusta Eberdt

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country) Md.

14- (Informant) Frederick P. Stein

(Address) Georgetown Rd Morrell Park

15- Filed NOV 3 - 1924 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 2 1924

17- I HEREBY CERTIFY, That I attended deceased from 10/25 1924 to 11/2 1924

that I last saw h.. alive on 11/1 1924

and that death occurred, on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 10/26/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Geo. A. Elwart M. D

19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Western Cemetery	Nov 5, 1924
20-UNDERTAKER, Geo. A. Paulus	ADDRESS 1532 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91609 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 D 91609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 Mt. Royal Ave. ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie E. Riale

(a) RESIDENCE NO. 1439 Mt. Royal Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
female	White	Widowed

An If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Thos. Riale

6 DATE OF BIRTH (month, day, and year) Mch 28 1848

7 AGE	76 Years	7 Months	3 Days	If LESS than 1 day, ... hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Doylestown, Pa.

PARENTS

10 NAME OF FATHER Jno Heard

11 BIRTHPLACE OF FATHER (city or town) Doylestown (State or country) Pa.

12 MAIDEN NAME OF MOTHER M Yeager

13 BIRTHPLACE OF MOTHER (city or town) Lebanon (State or country)

14 Informant Harry C. Riale. (Address) 3018 Harrison Ave.

15 NOV 3 - 1924 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to Oct 31, 1924.

that I last saw ~~her~~ alive on Oct 30, 1924

and that death occurred, on the date stated above, at 3 AM Oct. 31 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 1924

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Harry J. Beck M. D.

Nov 3, 1924 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Nottingham, Cecil Co Md.	Nov 4" 1924
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell,	W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91610

CERTIFICATE OF DEATH.

90 D 91610

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3802 Elm Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Burrier

(a) RESIDENCE NO. 3802 Elm Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Charles E. Burrier

6 DATE OF BIRTH (month, day, and year) Jan 29 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER Geo E. McCullough

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ellen Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Mrs Walter A Daly

(Address) 3802 Elm Ave

Filed NOV 3 - 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1924

17

I HEREBY CERTIFY, That I attended deceased from September, 1924, to Nov. 1, 1924, that I last saw her alive on Oct 31, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

a Aortic Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis (Rheumatic) Cerebral apoplexy.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. K. Marshall, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 4 19 24

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91611

CERTIFICATE OF DEATH.

23 161-002

D 91611

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1340 S. Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernst Lee Recklenwald

(a) Residence No. 1340 S Charles St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6-DATE OF BIRTH (month, day and year): Oct 31st 1924

7-AGE: ....yrs. 2 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Stephen J. Recklenwald

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Ella Hollweg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14-(Informant): Stephen J Recklenwald

(Address): 1340 S Charles St

15-Filed NOV 3 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 2 1924

17-I HEREBY CERTIFY, That I attended deceased from 10/31 1924 to 11/2 1924

that I last saw h— alive on 11/1 1924

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows: Surgery Due to instruments

Shock Delivery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Tandy M. D.

, 19 (Address) 1340 S Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, 11-3, 1924

20-UNDERTAKER: E & B Slade — ADDRESS 115 E Wood St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 D 91612

1-PLACE OF DEATH City of BALTIMORE (No. St. Joseph's Hospital St., 8 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A (Brown) Katthoffer

(a) Residence No. 2324 E. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Katthoffer

6-DATE OF BIRTH (month, day and year) 9/1/1844

7-AGE. 80 yrs. 2 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Brooklyn N.Y.

PARENTS

10-NAME OF FATHER John Collins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Everhart (Address) 2324 E. Preston St

15- Filed NOV 3 - 1924 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1924 to Nov 2 1924 that I last saw h[illegible] alive on Nov. 2 1924 and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Terminal Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility - Cholecystitis + Cholelithiasis (Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. B. Sybert M. D

, 19 (Address) 81 Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London M.R. Cem	11/5/24, 19
20-UNDERTAKER. Geo. J. Ruth	ADDRESS 1735 Hanford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

91613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 D 91613

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Belmont Ave ST., 27 WARD)

2-FULL NAME Emma Bauer

(a) RESIDENCE No. 14 Belmont Ave ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugo Bauers

6 DATE OF BIRTH (month, day, and year) Dec 13 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Bennecos

11 BIRTHPLACE OF FATHER (city or town) France (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hugo Bauer (Address) 14 Belmont Ave

15 Filed NOV 3 - 1924 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1924, to Oct 31, 1924.

that I last saw he alive on Oct 31, 1924.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) W. W. Peard, M. D.

11-1, 1924 (Address) 1 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	11/3 1924
20 UNDERTAKER George J Ruth	ADDRESS 1335 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. WARD) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rebecca Hoson (Hoson)

(a) RESIDENCE NO. 3414 Anchentoroby Terrace WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ? ds. How long in U. S., if of foreign birth? 35 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Hoson

6 DATE OF BIRTH (month, day, and year) — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER ? Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Debovitzld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Deceased

(Address)

15 Filed NOV 3 - 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1924, to Nov 2, 1924, that I last saw h e alive on Nov 2, 1924, and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) 8 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/27/24

Was there an autopsy? No

What test confirmed diagnosis? X rays - oesophagoscopy

(Signed) B. Price, M. D.

(Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 11/3 19 24

20 UNDERTAKER Jack Levy

ADDRESS Fremont

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91615
1742 15

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91615

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Ella Nichols

(a) RESIDENCE No. 1319 Ashland Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
54	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Jas. Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 3 - 1924 HUBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Nov 1, 1924, that I last saw h alive on Nov 1, 1924 and that death occurred, on the date stated above, at 7 25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertensive Cardio Vascular disease

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No yrs

What test confirmed diagnosis?

(Signed) Louis E. Marlow M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Nov 3 19 24

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1722 Ashland

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 B 91616

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD)

2-FULL NAME Maggie Scales

(a) RESIDENCE No. 1723 Maryland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow.

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Chas. Robertson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed NOV 3 - 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 1 1924

17

I HEREBY CERTIFY, That I attended deceased from 10 - 2 .1924 to 11 - 1 .1924

that I last saw her alive on 10 - 31 .1924

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Myocardial Insufficiency

(duration) yrs. 2 mos (Note) ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab + Autopsy

(Signed) Claude A. Dean, M. D.

11 - 1 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakmont Cemetery	Nov. 3 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1125 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91617

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 91617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Home for the Aged St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Kerlinger

(a) Residence No. Little Sisters of the Poor St., Preston Ward 9 Fullerton

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) Dec 16 44

7-AGE, 79 yrs. 10 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Manchester (State or Country) Carroll Co

PARENTS.

10-NAME OF FATHER, Jacob Kerlinger

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Catherine Kerlinger

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Sister Irenaeus

(Address) Little Sisters of the Poor

15- Oct 31 1924 ROBERT P. KRAUTER Registrar.

NOV 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 30/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1924 to Oct 30 1924, that I last saw him alive on Oct 26 1924, and that death occurred, on the date stated above, at 7 A.M. The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Oct 31, 1924 (Signed) F C Warner, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mount Ridge Cem	Nov 3, 1924
20-UNDERTAKER.	ADDRESS
H M Routson	2238 N Monroe

Cor.—1-12-23—M&T—100 Bka.

91618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24001 D 91618

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Thomas Ave., 15 WARD)

2-FULL NAME Lydia M.c Kinney

(a) RESIDENCE No. 1826 Thomas ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Mc Kinney

6 DATE OF BIRTH (month, day, and year) Jan. 9 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Emanuel Fogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Pippinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Chas J. Mc Kinney
(Address) 1826 Thomas ave

15 Date NOV 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Contusions

(duration) yrs. mos. ds.

(Signed) Jos. J. Heuisler, M. D. (Coroner.)

(Address) 2 E Fayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov 3 1924

20 UNDERTAKER W M Routson

ADDRESS 2236 N Arlington

FILL PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91619

CERTIFICATE OF DEATH.

38 D 91619

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

2-FULL NAME Edward Rowley (Edward L. Rowley)

(a) RESIDENCE NO. 836 West Pratt Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia V. Rowley

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	9	0	

8 OCCUPATION OF DECEASED (Retired)

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Edward L. Rowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland ?

12 MAIDEN NAME OF MOTHER Amelia Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland ?

14 Informant Municipal Hospital Records

(Address)

Filed NOV 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 31 1924

17

I HEREBY CERTIFY, That I attended deceased from 10 - 8, 1924, to 10 - 31, 1924

that I last saw him alive on 10 - 31, 1924

and that death occurred, on the date stated above, at 8 50 a. m.

The CAUSE OF DEATH* was as follows:

C. N. S Syphilis (General Paresis)

(duration) 1 yrs. (History) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Drew, M. D.

10-31 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem. Hampden	Nov 3 1924
20 UNDERTAKER Hoyt & Cook	ADDRESS 1003 N. Bethel

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

† 44 D 91620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., 1st WARD)

2-FULL NAME Mr. Edward D. Stewart (STEUART)

(a) RESIDENCE NO. 101 Shealy Ave. ST., WARD Towson. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. C. Stewart

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Stewart

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record
(Address)

15 NOV 3 - 1924 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1924, to Nov. 2, 1924, that I last saw him alive on Nov. 2, 1924 and that death occurred, on the date stated above, at 2 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 30, 1924

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A.B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monte Maria Cemetery, Towson, Md

DATE OF BURIAL 11/4 1924

20 UNDERTAKER W. E. Means & Son

ADDRESS 805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91621

CERTIFICATE OF DEATH.

57 D 91621

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Woodley ST., 16 WARD)

2-FULL NAME Emma J. Seabrease

(a) RESIDENCE No. 1112 Woodley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 11-1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (Oct)

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Shellenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Instal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Violet A Burgess

(Address) 1112 Woodley St

15 Filed NOV 3 - 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Oct 31, 1924.

that I last saw h.. alive on Oct 31, 1924.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Dudley Hoag, M. D.

(Address) 129 Park Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Nov. 3 1924

20 UNDERTAKER George L. Schwab — ADDRESS 1101 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1575 2 D 91622

CERTIFICATE OF DEATH.

D 91622

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 28 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry K. Bush

(a) RESIDENCE No. Woodlawn Md ST. ..... WARD .....

(Usual place of abode) Carroll Park Corner of Forest Ave. & Carey Pk.

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... ntin.
	64	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) ob

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924, to Nov 1, 1924, that I last saw h alive on Nov 1, 1924, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene L. Shaw, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11/3 1924
20 UNDERTAKER Fredk A. Cole	ADDRESS 1411 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 91623

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Women's Hosp. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hannah White Frush

(a) Residence No. Forest Park, 4007 Springdale ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 2, 1882

7-AGE, 42 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry S. Frush

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Hannah White Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Mary E. Frush

(Address) Forest Park 4007 Springdale ave City

15- Filed ..... 19..... Registrar.

OV 3 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Nov 3, 1924, that I last saw h.r alive on Nov 3, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Ovary

unknown

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinomatosis, general

unknown

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of Jan 14, 1924

Was there an autopsy? No

What test confirmed diagnosis* Laboratory tests

(Signed) J. Ogle Warfield, Jr. M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	Nov 6, 1924
20-UNDERTAKER.	ADDRESS
J. D. Mitchell	1201 N. Fayette

(over)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS I

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91624

CERTIFICATE OF DEATH.

+ 31

D 91624

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Mrs. Anna Callahan

(a) RESIDENCE NO. 1016 St Paul ST., WARD Catonsville Md

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred = yrs. 1 mos. = ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas H. Callahan

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm W. Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record

(Address)

15 Filed 3 - 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/24

17

I HEREBY CERTIFY, That I attended deceased from 9/29/24 19 ..... to 11/2/24 19 ....., that I last saw h alive on 10/31/24 19 ..... and that death occurred, on the date stated above, at 12 M. p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tubercular Colitis

Pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) K. W. Dilley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centerville Md. via Pope Mills

DATE OF BURIAL Nov 3 1924

20 UNDERTAKER Chas H. Grimes & Son

ADDRESS 118 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91625

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Patapsco ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Garrity

(a) RESIDENCE No. 1733 Patapsco ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Garrity

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

PARENTS

10 NAME OF FATHER Patrick McDonald

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Gillan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. John Butler

(Address) 1733 Patapsco St.

15 Filed NOV 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 19 24

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 19 24, to Oct 31, 19 24, that I last saw h alive on Oct 30, 19 24, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Ulceration Colon

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pendicitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical

(Signed) [illegible] M. D.

11 3. 1924 (Address) 1 Wendall Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov. 4 19 24

20 UNDERTAKER Margaret G Flynn — ADDRESS 1122 Light

Cor.—1-12-23—M&T—100 Bks.

91626

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002 D 91626

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 27 WARD)

2-FULL NAME William Upton Long

(a) RESIDENCE NO 204 Emmel ~~Long~~ Ave. Lanvale ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred all 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 8/1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	30	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

063

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie M. Upton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas City Mo.

14 Informant Mrs. Francis Long
(Address) 204 EMMEL AVE

15 NOV 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & other injuries

(Street car accident)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Adoration) yrs. mos. ds.

(Signed) J. S. Collins, M. D.
(Coroner.)

Nov 3 24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 5 1924
20 UNDERTAKER Margaret G Flynn	ADDRESS 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91627

CERTIFICATE OF DEATH.

11-001 ✓

D 91627

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 638 W. Fayette ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Carroll

(a) RESIDENCE NO. 638 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Sept 1886

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
38	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Lena Wright

(Address) 640 W. Fayette St.

15 Filed ..., 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1924, to Nov. 2, 1924.

that I last saw her alive on Nov. 2, 1924.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia following La Grippe.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Driscoll, M.D.

, 19 (Address) 1211 Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a.a. Co.	Nov. 3 1924
20 UNDERTAKER	ADDRESS
Margaret G Flynn	1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM TYAGE

Spec.—1-12-23—M&T—500 Bks.

D 91628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91628

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 Garrison Ave ST., 15 WARD)

2-FULL NAME Maria T Hussey

(a) RESIDENCE No. 2409 Garrison Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael B. Hussey

6 DATE OF BIRTH (month, day, and year) March 1, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police matron

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Kelliher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James Murray
(Address)

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 24

17

I HEREBY CERTIFY, That I attended deceased from November 22 19 24 to Nov. 1 19 24, that I last saw her alive on Nov. 1 19 24, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach and intestine

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edw V. Coolahan, M. D.
Edward V. Coolahan.

, 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 4 1924

20 UNDERTAKER H. C. Branning & Son — ADDRESS 517 N Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. A.K.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91629

CERTIFICATE OF DEATH.

31 D 91629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Washington

(a) RESIDENCE No. 431 Asquith st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Washington

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Morgan Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise Gainns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed Robert P. Harrison Registrar

NOV 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1924, to Oct. 31, 1924, that I last saw her alive on Oct. 31, 1924, and that death occurred, on the date stated above, at 11.10 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard Richards M. D.

10-31-24 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va DATE OF BURIAL Nov. 3 1924

20 UNDERTAKER Wm J. Y. Locke ADDRESS 1302 Jeffer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91630

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1184 N. Ostend ST.: 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Zarcone

(a) RESIDENCE. No. 1184 N. Ostend ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul Zarcone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Helen Eiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Paul Zarcone.
(Address) 1184 N Ostend st.

15 Filed NOV 3 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 24

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 19 24, to Nov 1, 19 24, that I last saw h. alive on Nov 1, 19 24, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C Zirnetto M. D

11/2, 19 24 (Address) 1299 Williams st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. A. Co.	11/4/24 19

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91631

CERTIFICATE OF DEATH.

58-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 403 E. 25th St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Greene

(a) Residence No. 403 E. 25th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert C. Greene

6-DATE OF BIRTH (month, day and year) July 8 1865

7-AGE. 59 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Lawrence Moran

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Sarah Connolly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland.

14- (Informant) Mary A. Scanlon

(Address) 403 E. 25th St.

15-

Filed NOV 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924 to Oct. 31, 1924

that I last saw h. alive on Oct. 31, 1924

and that death occurred, on the date stated above, at 4.40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Acuta

(Duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Dysentery

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jerge C. Clark M. D.

Nov. 2, 1924 (Address) 1140 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet	Nov. 5, 1924
20-UNDERTAKER.	ADDRESS
E. A. Pickell, Jr.	2101 E. 22nd St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91632

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 91632

CERTIFICATE OF DEATH.

94-68

1-PLACE OF DEATH

City of BALTIMORE: (No. #2- Tyler St St., 9 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida B. Nicholson

(a) Residence No. #2- Tyler St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) 9/3/24

7-AGE. — yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... mins.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS:

10-NAME OF FATHER, Marion Nicholson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Salisbury Md

12-MAIDEN NAME OF MOTHER, Mattie Stayton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Marion Nicholson

(Address) #2- Tyler St

15- Filed ..... Robert P. Harrison, Registrar.

1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924 to Nov 2, 1924

that I last saw h.. alive on Nov 2, 1924

and that death occurred, on the date stated above, at 10 20 A m.

The CAUSE OF DEATH* was as follows:

A Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W Whitehead, M. D.

11/3, 1924 (Address) 2800 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery — DATE OF BURIAL, 11/5/24, 19....

20-UNDERTAKER, George J. Puth — ADDRESS 1235 Hanover

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

GV3

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91633 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91633

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1014 E. Preston St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Towson Helm

(a) Residence No. 1014 E. Preston St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 3, 1860

7-AGE,	If LESS than 1 day,
64 yrs. 9 mos. 0 ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): (At Home)

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: John F. Helm

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Frances Ann Towson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland

14- (Informant): Mrs. Samuel W. Frizzell

(Address): 1014 E. Preston Street

15- Filed NOV 3 - 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from January, 1922, to Nov. 3rd, 1924, that I last saw h[illegible] alive on Oct. 15th, 1924, and that death occurred, on the date stated above, at 1.50 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart.

1 hour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Chronic Endocarditis Partial Hemiplegia Left Side

(Duration) 2 yrs mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? Yes

What test confirmed diagnosis? ~

(Signed) Jefferies Buck, M. D.

11-3 1924 (Address) 2844 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Nov. 6, 1924
Greenmount Cem	
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 N. Carey St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91634 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91634

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Athol Ave. Cor Frederick Rd. Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Lee Walker

(a) Residence No. Athol Ave Cor Frederick Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) July 17, 1904

7-AGE.	If LESS than 1 day.
20 yrs. 3 mos. 14 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Harry L. Walker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. McNally

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant) Miss Edith Walker

(Address) Athol Heights, Irvington

15- Filed Nov 7 1924, 19? Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 1- 24

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to Nov 1, 1924, that I last saw h-e alive on Nov 1, 1924, and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(Duration) yrs. mos. 1/2 hr

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W. Jane M. D.

Nov 3, 1924 (Address) Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	Nov. 4, 1924
20-UNDERTAKER.	ADDRESS
H. W. Mears & Son	805 N. Calvert St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91635

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 ✓ D 91635

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Kellam

(a) RESIDENCE NO. 1426 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of deceased Era Kellam

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Chaim Kellam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A B Kellam (Address) 1426 E Lombard St

15 Filed ....., 19.. Robert P. Harrison, Registrar

GV4-1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1924, to November 3, 1924, that I last saw him alive on November 3, 1924, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor J. Fry M. D.

Nov. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Wilson Road

DATE OF BURIAL 11/6 1924

20 UNDERTAKER Jack Laurs

ADDRESS 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

D 91636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 91636

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 15 WARD)

2-FULL NAME David Zalis

(a) RESIDENCE No 2514 Kelworth Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 4, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Zalis

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Kleinman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Mother
(Address)

15 Filed NOV 4 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1924, to Nov 3, 1924, that I last saw him alive on Nov. 3, 1924, and that death occurred, on the date stated above, at 10¹⁵ a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Laryngeal

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

11/3, 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 11/4 1924

20 UNDERTAKER Jack Levin — ADDRESS 1424 E Baltimore St.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91637

CERTIFICATE OF DEATH.

D 91637

REGISTERED NO. 159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 N. Washington St.: 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Grill.

(a) RESIDENCE. No. 1024 N. Washington St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1st 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Franklin H. Grill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gladys M. Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Franklin H. Grill.
(Address) 1024 N. Washington St

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11—3 1924

17 I HEREBY CERTIFY, That I attended deceased from 11—2 1924, to 11—3 1924, that I last saw h[illegible] alive on 11—3 1924, and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Fulminating Sepsis
Toxemia Puerperal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Syph.) Prenatal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Kruse, M. D.

11-3-24 (Address) 600 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery Nov. 4. 1924

20 UNDERTAKER — ADDRESS

Henry Hoch Son 1301 E. Eager St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91638

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 91638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lowndes & Wyonoke Aves St. 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Wright

(a) Residence No. Lowndes & Wyonoke Aves St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced, HUSBAND of (or WIFE of) Eva Wright

6-DATE OF BIRTH (month, day and year) Jan 11th 1854

7-AGE. 70 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John T. Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Hetty Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-

(Informant) Harry E. Wright

(Address) 1928 E. 31st St.

15-

Filed NOV 4 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 2/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924 to Nov 2, 1924

that I last saw him alive on Nov 1 1924

and that death occurred, on the date stated above, at 1-a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma -

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Bronchitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) W S Lebrun M. D.

11/3, 1924 (Address) 6227 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery — DATE OF BURIAL. 11/4, 1924

20-UNDERTAKER George J Ruth — ADDRESS 1435 Harford Ave

PERAH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spsc—12-23-21—E.B.R.S.—400 Bks.

D 91639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91639

1-PLACE OF DEATH

Registered No. 16591

City of BALTIMORE: (No. 731 S. Ellwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mollie M. Schneider

(a) Residence No. 731 S. Ellwood Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Schneider

6-DATE OF BIRTH (month, day and year) Jan 6, 1860

7-AGE. 64 yrs. 9 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None At Home

(b) General nature of industry, business, or establishment in which employed (or employer). Housework

(c) Name of employer. self

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Herman Bush

11-BIRTHPLACE OF FATHER (city or town) not known (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Not Known (State or Country), Germany

14-

(Informant) John Schneider

(Address) 731 S. Ellwood Ave

15-

Filed NOV 4 - 1924 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from about June 1, 1924 to Nov. 1, 1924

that I last saw her alive on Oct 31, 1924,

and that death occurred, on the date stated above, at 1:55 a. m.

The CAUSE OF DEATH* was as follows:

Amoebic dysentery

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Gen. Cachexia, Starvation (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Emetine intravenously

(Signed) [illegible] M. D.

10/2, 1924 (Address) 1014 S. Ellwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov. 4, 1924
20-UNDERTAKER.	ADDRESS
H. Vander & Sons	110 E. Lee St.

NO. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91640

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 938 W. Saratoga St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Margaret Babb

(a) Residence No... 938 W. Saratoga St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) ~~Divorced~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 24 - 24

7-AGE, ... yrs. 4 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ... no

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (City or town) Balto City
(State or Country)

PARENTS.

10-NAME OF FATHER, Archie Babb

11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country) U. S.

12-MAIDEN NAME OF MOTHER, Jane Owens

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) U. S.

14- (Informant) Archie Babb
(Address) 938 W. Saratoga St.

15- Filed: NOV 4 1924 16- Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3, 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov. 3, 1924, that I last saw her alive on Nov. 2, 1924, and that death occurred, on the date stated above, at ..... m. The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Morley Hoag M. D.

Nov 4, 1924 (Address) 29 Cook Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	11-4-24
20-UNDERTAKER.	ADDRESS
Daniel Corbin	Penna ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91641

CERTIFICATE OF DEATH.

D 91641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD) 16

2-FULL NAME Mary Duncan

(a) RESIDENCE No. 832 N. Stricker st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roderick J. Duncan

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mallie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed NOV 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1924, to Nov. 2, 1924,

that I last saw her alive on Nov. 2, 1924,

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) R. Kluver, M. D.

11-2-24 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 11-5-24

20 UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91642

CERTIFICATE OF DEATH.

179 D 91642

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Donnell r 29th ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth R Dawson

(a) RESIDENCE No. 10 Donnell r 29th ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James W Dawson

6 DATE OF BIRTH (month, day, and year) Oct 4/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER James Spence

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Stell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant James W Dawson
(Address) 10 Donnell r 29th

15 Filed NOV 4 1924 By Robert P. Harrison Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
(10) Burns over whole body. Clothes caught fire from Coal Oil Stove Accident (duration) ..... yrs. ..... mos 1/2 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenlon (Coroner.), M. D.

Nov 3, 1924 (Address) 700 Cherry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem — DATE OF BURIAL Nov 4 1924

20 UNDERTAKER John Ulrich — ADDRESS 2008 Ulleas

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91643

CERTIFICATE OF DEATH.

D 91643

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 E. Madison ST.; 10 WARD)

REGISTERED No. C 101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Junius Henderson

(Residence in Baltimore: No. 1016 E. Madison St.; 3 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1893
(Month) (Day) (Year)

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Georgetown Co. S. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER, unknown.

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Henderson

(Address) 1016 E. Madison St

15-

Filed....., 191....

Registrar.

1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 11 (Month) 1 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1924, to Nov 1 1924, that I saw him alive on Nov 1 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....Lobar Pneumonia.....

..... (Duration).....yrs.....mos.....7.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) A. L. Bornstein M. D.

11/1, 1924. (Address) 733 Ausquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Georgetown S.C. DATE OF BURIAL, Nov. 5, 1924

20-UNDERTAKER Chas. E. Johnson ADDRESS 416 N. Carolina

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 12-23-21—E.B.R.S.—400 Blks.

D 91644

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 91644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hosp

Registered No.....

City of BALTIMORE: (No..... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Burrell

(a) Residence No. 1212 Division St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1879

7-AGE 45 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Elevator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS:

10-NAME OF FATHER, Robt. Burrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER Josephine Lockley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14- (Informant) Mollie Jones

(Address) 1429 W. Lafayette Ave.

15- Filed NOV 4 - 1924 192 Robert P. Harris Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 2-1924

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1924 to Nov 2, 1924, that I last saw h. alive on Nov 2, 1924 and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

General T. B. with tuberculous osteomyelitis left femur + tibia

(Duration) X yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 19-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B. Sybert M. D.

, 19 (Address) St Joseph's Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Middlesex Co. Va. DATE OF BURIAL. 11-6 1924

20-UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carolina Ave

Urbana

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 1291

City of BALTIMORE: (No. 2018 N. Bentlou St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida Schulman

(a) Residence No. 2018 N. Bentlou St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? 13 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Auser Schulman

6-DATE OF BIRTH (month, day and year)

7-AGE. 60 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Meyer Zunderlowitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Bessie Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Auser Schulman

(Address) 2018 N. Bentlou St

15- Filed NOV 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3/24

17- I HEREBY CERTIFY, That I attended deceased from Dec - 5, 19 24 to Nov - 3, 19 24

that I last saw h[illegible] alive on Nov - 3 19 24

and that death occurred, on the date stated above, at 9309 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arterio sclerosis —

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinic - Symptoms

11/5, 1924 (Signed) Dan Friedman, M. D.

(Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pikesville Southern Line

DATE OF BURIAL, 11/4, 1924

20-UNDERTAKER. Sol Levinson & Bro

ADDRESS 1127 E Balto St

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91646

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Spring ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah. Wooden

(a) RESIDENCE NO. 614 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
femal	colord	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work house. work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. D (State or country)

PARENTS

10 NAME OF FATHER Joseph. price

11 BIRTHPLACE OF FATHER (city or town) Md. D (State or country)

12 MAIDEN NAME OF MOTHER un. known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Gertrude Bring

(Address) 614 N. Spring Ste

15 DEC 4 - 1924 Robert P. Harrison. .19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 — 2 — 1924

17 I HEREBY CERTIFY, That I attended deceased from 10 — 28 —, 1924, to 11 — 2 —, 1924, that I last saw h[illegible] alive on 11 — 1 —, 1924, and that death occurred, on the date stated above, at 6,25 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis Indefinite. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jos. H. Carpenter, M. D.

11-2-1924 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Isreal cemetery — DATE OF BURIAL: nov 4 1924

20 UNDERTAKER Edward Bryon — ADDRESS 631 arlemp

DV4

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91647

CERTIFICATE OF DEATH.

91647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Lawson ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Perry

(a) RESIDENCE No. 1404 Lawson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1923

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs. or 1 min.
X	1	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Jennie King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant —

(Address)

15 Filed NOV 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3, 1924

17 I HEREBY CERTIFY, That I attended deceased from 10.30, 1924, to 11.3., 1924, that I last saw h alive on 11.3.24, 19—, and that death occurred, on the date stated above, at 12.05 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. — mos 7 ds.

Epid Meningitis

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

19 (Signed) J Edw Holmes, M. D.

(Address) 107 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co. DATE OF BURIAL Nov 4 1924

20 UNDERTAKER Geo. L. Evans. ADDRESS [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. Perkins. The Rochambeau Charles & Franklin

D. 91648 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 91648

CERTIFICATE OF DEATH. 3 Ward 4020

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1122 S. Paca. St., W 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Boswell.

(a) Residence No. 1122 S. Paca. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katie E Boswell.

6-DATE OF BIRTH (month, day and year) March 19th 1858

7-AGE 66 yrs. mos. ds. If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Not Known.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14-Informant Katie E Boswell

(Address) 1122 S Paca St

15-Filed NOV 4 - 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from September 9th 1924 to November 1st 1924.

that I last saw him alive on November 1st 1924.

and that death occurred, on the date stated above, at 4.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) — yrs. — mos. 4 ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Wm. D. Perkins, M. D.

, 19 (Address) 1W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 192
Loudon Park	11-5-24
20-UNDERTAKER, James D. Gwynn Son	ADDRESS 1000 E Paca St

NO—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

107-001

D 91649

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1825 Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin E. Cole

(a) Residence No. 1825 Hanover St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Cole

6-DATE OF BIRTH (month, day and year) Aug. 14 1892

7-AGE, 32 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ship Caulker

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md. (State or Country),

PARENTS.

10-NAME OF FATHER, John T. Cole

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Bargell Bosely

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country),

14- (Informant) Mrs. Cole

(Address) 1825 Hanover St.

15-

Filed 1924 16-Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 19 24 to Nov 1 19 24

that I last saw h. alive on Nov 1 19 24

and that death occurred, on the date stated above, at 7 Pm m.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. L. Campbell M. D.

11/4/24 19 (Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	11/4 19 24
20-UNDERTAKER.	ADDRESS
D. Fenw McCully	130 E. Fort

Burial Permit Clerk

OV4 1924

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91650

D 9165

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1014 Lamont Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 1)

2-FULL NAME Thomas Kucera (Kutcher)

(a) RESIDENCE NO. 816 N. Durham St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kucera

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Street-sweeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Balto. City 816

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph Kucera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

4 Informant Anna Kucera
(Address) 816 N. Durham St

15 Filed ....., 192 Robert ... Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Empyema-Probable pneumonia

(Possibly T.B.)

(duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. .....

(Signed) J. S. Walter, M. (Coroner.)

11/3/24. 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

20 UNDERTAKER Frank Enoch

PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should write plainly, so that it may be properly classified. Exact statement of CAUSE OF DEATH is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91651

CERTIFICATE OF DEATH.

+90 D 91651

1-PLACE OF DEATH University Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Owen Hall

(a) RESIDENCE NO. Madonna Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Mellon

6 DATE OF BIRTH (month, day, and year) Feb. 16 - 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Black Horse (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Robert Hall

11 BIRTHPLACE OF FATHER (city or town) Black Horse (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Louisa Berry

13 BIRTHPLACE OF MOTHER (city or town) Norrisville (State or country) Harford Co Md

14 Informant William Hall (Brother) (Address) R.D. Whiteford Md

NOV 4 Filed 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-22-24, 19 ..., to 11-3-24, 19 ...

that I last saw him alive on 11-3-24, 19 ...

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Synovial Sarcoma of Thoracic Myocardium

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) [illegible] M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Grove Cem Balto Co Md — DATE OF BURIAL Nov 7 1924

20 UNDERTAKER E. H. Kurtz & Son — ADDRESS Garrett Lands Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 91652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91652

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 719 Bay (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah F. Canoppi

(a) RESIDENCE NO. 719 Bay St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. Canoppi

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...brs. or ....min.
65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Merrill

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Ed. Canoppi
(Address) 719 Bay St

15 Filed NOV 4 - 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma
Large Intestine
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrissey M. D.
(Coroner.)
Nov 3, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hanbel	Nov 4 1924
20 UNDERTAKER CHENOWETH & SON	ADDRESS 1617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91653

CERTIFICATE OF DEATH.

D 91653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3532 Roland Ave WARD) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thirza Ellen Stone

(a) RESIDENCE NO. 3532 Roland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August C. Stone

6 DATE OF BIRTH (month, day, and year) Aug 13 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	75	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Earnest Wells (Address) 3532 Roland Ave

15 Filed ... 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1924, to Nov 3, 1924, that I last saw h... alive on Oct 31, 1924, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall bladder

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 25/24

Was there an autopsy? No

What test confirmed diagnosis? Condition found at time of operation

(Signed) Ross Townsend, M. D.

11/3, 1924 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hanover	Nov 5 1924

20 UNDERTAKER CHENOWETH & SON 3617 CHESTNUT AVE. ADDRESS

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

175 806 D 91654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 91654

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) RESIDENCE NO. 3734 Hickory Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hose (M)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

UV4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/27, 1924, to 11/2, 1924, that I last saw him alive on 11/2, 1924, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis Jaw

(duration) yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) Septicemia, Metastatic Joint Infections

(duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? Yes Date of 10/30/24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James Arthur Wesley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 5 1924
20 UNDERTAKER	ADDRESS
GREENWETH & SON	1417 CHESTNUT AVE

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91655

CERTIFICATE OF DEATH.

36 804

D 91655

1-PLACE OF DEATH West Balt. general Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette Ave & Dukeland ST. WARD 58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs walter Joyner

(a) RESIDENCE No. Fait Ave (2702) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Joyner.

6 DATE OF BIRTH (month, day, and year) March 10 - 1895

7 AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. md.

PARENTS

10 NAME OF FATHER Thomas B. Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Ellen Shepard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Barbara Joyner (Address) 2702 Fait Ave.

15 Filed Nov 5 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/15/ .1924. to 11/1/ .1924.

that I last saw h/ alive on 11/1/24 .1924.

and that death occurred, on the date stated above, at 1:35 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Left Kidney.

Indefinite (duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9/17/24

Was there an autopsy? no

What test confirmed diagnosis? clinical & operative

(Signed) James Hubert Alderson M. D.

(Address) West Balt Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL Nov 5 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

10V4 - 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91656 D 91656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1703 S. Bouldin St., 26 Ward) 129

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Peter Dotterweich

(a) Residence No. 1703 S. Bouldin St., 26 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 17-1832

7-AGE. 92 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS

10-NAME OF FATHER, John Dotterweich

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant)..... Jacob Dotterweich

(Address)..... 17 S. Highland Ave.

15- Filed..... Robert P. Harrison Registrar.

1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 2-1924

17- I HEREBY CERTIFY, That I attended deceased from October 1 ..... 19 24 to Nov. 2 ..... 19 24

that I last saw him alive on Nov. 2 ..... 19 24

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ..... yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Allen C. Beecham M. D

11-3- 1924 (Address) 3139 E. Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL, Nov. 5th 1924

20-UNDERTAKER, Lilly & Zeiler ADDRESS 1031 Wolfe St

NOV 4 1924

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91657 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91657

96

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 838 N Saratoga St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Geo E Wooden

(a) Residence No. 838 N Saratoga St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug 2 1887

7-AGE, 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo Wooden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Georgiana Webb

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Geo. Wooden

(Address) 1252 Belnord Ave

15- Filed NOV 4 - 1924 Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Oct 31, 1924, that I last saw him alive on Oct 29, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Chronic Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Oct 31, 1924 (Address) 406 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cemetery DATE OF BURIAL, Nov 3 1924

20-UNDERTAKER, Mrs Geo A Hooper ADDRESS 406 W Saratoga

IN. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91658

D 91658

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Barclay St. WARD) 12

2-FULL NAME Henry Wells

(a) RESIDENCE NO. 3208 Barclay St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
82	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Morris
(Address) 3208 Barclay St

15 Filed NOV 4 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Nov 1, 1924, that I last saw him alive on Oct 31, 1924, and that death occurred, on the date stated above, at 9:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy and old age

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Hard work and age (duration) 80 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. M. Hall, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 11-4-24

20 UNDERTAKER David Easton

ADDRESS 916 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 91659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 S. Clinton ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Schwartz

(a) RESIDENCE NO. 1131 S. Clinton St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 65 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A.

6 DATE OF BIRTH (month, day, and year) May 14 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
78	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo M. Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Emma Schwartz

(Address) 1131 S. Clinton St

15 Robert P. Harrison,

NOV 4 - 1924 , 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct - 4 , 1924, to Nov - 2, 1924.

that I last saw him alive on Nov - 1 , 1924,

and that death occurred, on the date stated above, at 9 a , m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Hemiplegia (Rt) Nov

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? — At home (1131 S. Clinton St

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) William J. Driscoll, M. D.

11/3, 1924 (Address) 203 S. O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL Nov 3, 1924

20 UNDERTAKER Funkler & Finkler — ADDRESS 1757 Eager

Spec.—1-10-21—M&T—1500 Bks.

D 91660

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-01 D 91660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3133 Greenmount ave ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip L. Hofferbert

(a) RESIDENCE No. 3133 Greenmount ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Hofferbert

6 DATE OF BIRTH (month, day, and year) Dec 29 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 145

(b) General nature of industry, business, or establishment in which employed (or employer) Musical Instruments

(c) Name of employer

9 BIRTHPLACE (city or town) New Athens (State or country) O.

PARENTS

10 NAME OF FATHER Philip Hofferbert

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hess

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant J. Louis Hofferbert

(Address) 3133 Greenmount ave

15 Filed 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov 2, 1924, that I last saw h[illegible] alive on Nov 2, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis - Endocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alm T B Lemmon, M. D.

11/2, 1924 (Address) 1821 Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Nov 4 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 N. North Ave

ATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91661

CERTIFICATE OF DEATH.

100-00 D 91661

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: No. 1207 Lubecs alley ST., 4 WARD)

2-FULL NAME Theadore Smith

(a) RESIDENCE No 207 Lubecs alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 15 1924

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	9		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto City
(State or country)

10 NAME OF FATHER Norman Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md.

12 MAIDEN NAME OF MOTHER Ada Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md.

Informant Norman Smith
(Address) 207 Lubecs alley

Filed 1924 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or inquiry.~~ thereon and from the evidence obtained by said ~~inquest, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Jones M. D.
(Coroner.)

11-4, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 4 1924
20 UNDERTAKER	ADDRESS
W. R. G. Elliott	725 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91662 ✓ D 91662

CERTIFICATE OF DEATH.

X 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Doris Hahn

(a) RESIDENCE NO. Pasadena, A.A. Co. Maryland ST.... WARD....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) A.A. County (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw. Hahn

11 BIRTHPLACE OF FATHER (city or town) A.A. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hazel Seibert

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mother (Address)

15 Filed NOV 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924, to Nov 4, 1924, that I last saw h alive on Nov 4, 1924, and that death occurred, on the date stated above, at 12 05 a m

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Tracheotomy Date of 11/1/24

Was there an autopsy? N

What test confirmed diagnosis? Pos. culture

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy M.E. Church Cem — DATE OF BURIAL Balto 11-4-24

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.- 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91663

CERTIFICATE OF DEATH.

31 D 91663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Ridgely ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira M. Judkins

(a) RESIDENCE NO. 1137 Ridgely ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20	two	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk B&O.

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer B and O. R R

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Walter Judkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Pauly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gertrude Judkins

(Address) 1137 Ridgely

15 Filed , 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924, to Nov 2, 1924, that I last saw her alive on Oct 31, 1924, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Mullary Tuberculosis of Both Lungs

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Raymond H. Hamm, M. D.

Nov 3, 1924 (Address) Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Nov 5 1924
20 UNDERTAKER	ADDRESS
George L. Schmoke	1211 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91664

CERTIFICATE OF DEATH.

46 D 91664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1263 S. Calverton Road WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie T. Martin

(a) RESIDENCE. No. 1263 S. Calverton Rd. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Smith Martin

6 DATE OF BIRTH (month, day, and year) Nov. 20-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rachel Bradford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Sallie Tawes

(Address) 2155 Hollins St.

15 Filed ..... 19 .....

[illegible] KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1924, to Nov 4th, 1924, that I last saw her alive on Nov 4th, 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

(Address) 511 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov. 7 1924
20 UNDERTAKER	ADDRESS
George L. Schmidt & Bro. Inc.	2101 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Forester

D 91665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91665

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) On way to Mercy Hospital 25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma L. Forster

(a) RESIDENCE No. Kent & Pacific Ave ST., Westport WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara V.

6 DATE OF BIRTH (month, day, and year) Oct 3-1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54		28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ret. Insurance Agt.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm A Forster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Dittrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara V. Forster (Address) Kent & Pacific

15 Filed NOV 5 - 1924 ROBERT R. KRAUS Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Paralysis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) Whitelaw (Coroner.), M. D.

Nov 4, 1924 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place 4 months In the City of death ..... yrs., ... mos., ... ds. State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov. 5 1924
20 UNDERTAKER	ADDRESS
George L. Schwatka	901 Brdwy

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information
CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state
TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

D 91666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1002 D 91666

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Franklin Sq Hospital ST., ... WARD .....

2-FULL NAME Wilbie M. Adams

(a) RESIDENCE No. Dilight. Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice M. Adams

6 DATE OF BIRTH (month, day, and year) May 5 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Heating Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John A. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER — Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Alice M. Adams
(Address) Delight, Md.

15 Filed ..... 192.. ROBERT H. KRAUTER, Registrar

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following amputation both legs — Supposed to have been run over by street car

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Buxton Cox, M. D.
(Coroner)

Nov 4 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	11-5 1924
20 UNDERTAKER Robert Brooks & Son	ADDRESS Calhoun & Hollins

AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should state that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91667

CERTIFICATE OF DEATH.

179

D 91667

1-PLACE OF DEATH

City of BALTIMORE: (No. 19h. Belnordave St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Smith

(a) Residence No. 191. Belnordave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Geo. F. Smith

6-DATE OF BIRTH (month, day and year) Aug. 1854

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. — Vogel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) J. A. Smith

(Address) 191. Belnordave

NOV 5 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 2/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 19 24 to Nov. 2 19 24

that I last saw h[er] alive on Nov. 2 19 24

and that death occurred, on the date stated above, at 5.38a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis — Duration: 4 days

Nephritis —

Myocarditis —

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho - Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Artigiani M. D

, 19 (Address) 2402 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Nov. 5th 1924

20-UNDERTAKER. J. A. Moran — ADDRESS 3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91668

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
D 91668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3022 E. Pratt St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Wallace

(a) Residence No. 3022 E Pratt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Michael Wallace

6-DATE OF BIRTH (month, day and year) Feb. 29th 1856

7-AGE. 68 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Havredegrace Md.

PARENTS.

10-NAME OF FATHER, Thos. Kane

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget Mulcahy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant)..... Jas. H. Wallace
(Address)..... 3022 E. Pratt St.

15- Filed NOV 5 - 1924 19.. Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 2, 1924

17a I HEREBY CERTIFY, That I attended deceased from Oct 26 24 to Nov 2 19 24

that I last saw h[illegible] alive on Nov 2 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell L. Mazar M. D.

11/4, 1924 (Address) 3478 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem.

DATE OF BURIAL. Nov. 5th 1924

20-UNDERTAKER. J. C. Moran

ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91669

31 D 91669

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 14 WARD)

2-FULL NAME Robert Murphy

(a) RESIDENCE NO. 1624 McCulloh street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Robert Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Minnie Claxton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Records

(Address) M.T.H.

15 Filed NOV 5 - 1924 ROBERT E. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1924, to Nov. 1, 1924,

that I last saw him alive on Nov. 1, 1924,

and that death occurred, on the date stated above, at 6.55 p. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) Richard Schorr, M. D.

11-1-24 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov 5 1924
20 UNDERTAKER Mrs RA Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

D 91670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91670

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 St Paul ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Goldsborough

(a) RESIDENCE NO. 924 St Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Goldsborough

6 DATE OF BIRTH (month, day, and year) June 23 * 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	81	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER James Gault

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Colquhoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London

14 Informant Mr Charles Goldsborough (Address) 924 St Paul

15 NOV 5 - 1924 ROBERT P. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to Nov. 3rd, 1924, that I last saw her alive on November 3rd, 1924, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Hypertension Cerebral Hemorrhage

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptomatology

(Signed) J. H. Chatard, M. D.

Nov 3rd, 1924 (Address) @ 1300 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 5 1924

20 UNDERTAKER Henry W Jenkins & Son Co ADDRESS Richard & Mc Collough

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91671

CERTIFICATE OF DEATH.

124 D 91671

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 540 Biddle ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. H. Davis

(a) RESIDENCE No. 540 N. Bidd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Davis

6 DATE OF BIRTH (month, day, and year) May 6, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Well digger

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John W. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ellen Davis

(Address) 540 Biddle St.

15 Filed ....., 19.... ROBERT H. KRAUTER Registrar

NOV 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1924 to Nov 3rd, 1924

that I last saw h— alive on Nov 3rd, 1924

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) A. E. Lee-Chew, M. D.

19 (Address) 1700 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Nov 5 1924

20 UNDERTAKER Samuel Ousley ADDRESS 1078 N Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91672

CERTIFICATE OF DEATH.

162 D 91672

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E Church ST. 22 WARD)

2-FULL NAME Lillian B Lilly

(a) RESIDENCE NO. 710 E Church ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs ... min.
			11 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wilbert Lilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna Bruffet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wilbur Lilly
(Address) 210 E. Church St

15 Filed ... 19... NOV 5 1924 ROBERT A. KRANTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 3 1924, to Nov 4 1924,

that I last saw h[illegible] alive on Nov 4 1924,

and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Difficult Labour

Cutting Wife's Throat by Lilly

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry B Cook, M. D.

Nov 4 19 (Address) 1130 E Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Nov 6 1924
20 UNDERTAKER	ADDRESS
E Schloman & Son	1037 Hanover

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91673

CERTIFICATE OF DEATH.

51 D 91673

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Offenbacker

(a) Residence No. 909 W. Lafayette St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Arthur Offenbacker

6-DATE OF BIRTH (month, day and year): July 4 - 1900

7-AGE: 24 yrs. 3 mos. 30 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House work.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): W. Va.

PARENTS.

10-NAME OF FATHER: Joseph Wesley

11-BIRTHPLACE OF FATHER (city or town) (State or Country): W. Va.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): W. Va.

14- (Informant): Mr. Arthur Offenbacker

(Address): 909 W. Lafayette St.

15- FILED NOV 5 - 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 3-1924

I HEREBY CERTIFY, That I attended deceased from Nov. 1 19 24 to Nov 3 19 24

that I last saw her alive on Nov 3 19 24

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Pelvic Inflam. and Peritonitis

(Duration) yrs. 11 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Phys. Exam

(Signed) Geo. B. Tyler, M. D.

, 19 (Address) St. Joseph Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Nov 5, 1924
20-UNDERTAKER: Chas. J. Gawen & Son.	ADDRESS: 901 Holliday St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91674

CERTIFICATE OF DEATH.

129 D 91674

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 37 E Church ST., 27 WARD)

2-FULL NAME Mary Brooks

(a) RESIDENCE No. 37 E. Church ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Brooks

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jamie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel Brooks
(Address) 37 E Church St

15 Filed NOV 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1 1924, to Nov 3 1924, that I last saw h— alive on Nov 3 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Bright Disease

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E Richard Lay, M. D.

, 19 (Address) 1340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn et	Nov 6 - 1924
20 UNDERTAKER	ADDRESS
L. E. Bruns & Son	Woodmont

Cor.—1-12-23—M&T—100 Bks.

91675

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 91675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore Athletic Club ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Georg Krug

(a) RESIDENCE No. 828 E. Preston (or Thurmont Md) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine S. Krug

6 DATE OF BIRTH (month, day, and year) Mar 12 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Krug

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anne Shmidt

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mr. Andrew Krug
(Address) 826 E. Preston St.

15 Filed NOV 5 - 1924 ROBERT R. KRAMER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

2 years. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. W. Kelly, M. D.

Nov 5 1924 (Address) 1059 Park (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Nov. 6 1924

20 UNDERTAKER Wm. Tickner & Son ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91676

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen Hospital St., WARD)

2-FULL NAME Libby May Taylor

(a) RESIDENCE NO: 159 Fremont Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 11 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Anthony K Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lidia A Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Taylor

(Address) 159 Fremont Ave

15 Filed NOV 5 - 1924, 19.. ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4/24 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924, to Nov 4 24

that I last saw h w alive on Nov 4, 1924

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Mitral regurgitation, Myocarditis & Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Yes Date of Oct 30, 24

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Jno A Fenwick, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Cemetery Pa — DATE OF BURIAL Nov 5. 1924

20 UNDERTAKER John O. Middleton — ADDRESS 1201 W Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91677

CERTIFICATE OF DEATH.

X 114 D 91677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hospital (ST.) WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie McAtee

(a) RESIDENCE No. Sparrows Point ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant H. E. Beard

(Address) Sparrows Pt Md

15 NOV 5 - 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/24 19

17 I HEREBY CERTIFY, That I attended deceased from 8 a.m. 10/30, 1924, to 10-31, 1924, that I last saw him alive on 10-30-24, 19, and that death occurred, on the date stated above, at 10 3/4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastroenteritis (duration) yrs. mos. about ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 253 McAllen St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Evergreen Cemetery — DATE OF BURIAL Nov 5 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91678

CERTIFICATE OF DEATH.

D 91678

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2529 Lauretta Ave St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Winfield W. Rowels

(a) Residence No. 2529 Lauretta Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 19/1924

7-AGE. ..... yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Zachriah W. Rowels

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Mabel M Wunderlich

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Mrs Mabel M Rowels

(Address) 2529 Lauretta Ave

15- Filed NOV 5 1924 ROBERT A. KRAUTZ Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1924 to Nov 4 1924

that I last saw h— alive on Nov 4 1924

and that death occurred, on the date stated above, at 7.55 p m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Amelia Klop M. D.

11-5 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov 5 1924
20-UNDERTAKER.	**ADDRESS**
John F Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Blades ✓

D 91679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91679

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 23 N. Luzerne ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliana Schmitt

(a) RESIDENCE. NO. 23 N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmitt

6 DATE OF BIRTH (month, day, and year) Sept 30 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Polster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Barbara Geisler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Mary Schneider

(Address) 23 N. Luzerne

NOV 5 - 1924

Filed ROBERT A. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 - 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to Nov 3, 1924, that I last saw h[illegible] alive on Nov 2, 1924, and that death occurred, on the date stated above, at 7 20 AM

The CAUSE OF DEATH* was as follows:

Diabetes Mel-

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) A G Slades, M. D.

19 (Address) 4376 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov. 6 1924

20 UNDERTAKER Jos. J. Herr

ADDRESS 150 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 91680

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 N. Durham ST., 8 WARD)

2-FULL NAME Julia R. Reinhardt

(a) RESIDENCE NO. 1616 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21st 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.....min.
	3	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George T. Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary J. Diegelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. George T. Reinhardt

(Address) 1616 N. Durham St

15 Filed NOV 5 - 1924 Registrar ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-3, 1924, to 11-4, 1924, that I last saw h[er] alive on 11-4, 1924, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Thyroidal Insufficiency

(duration) yrs. mos 1- ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

(Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 6 1924

20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E Eager St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91681

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1419 E Monument St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. C. Fields

(a) Residence No. 1419 E Monument St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) July 19 1902

7-AGE. 22 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, August Fields

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mamie Pfister

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Mrs Jas E Nelsch (Sister)

(Address) 2609 E Monument St

NOV 5 - 1924

ROBERT R. KRAMER Registrar

Build Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-2-1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to Nov 2 1924

that I last saw him alive on Nov 2 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Laryngitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. N. Bishop M. D.

Nov 4, 1924 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn	11-6, 1924
20-UNDERTAKER.	ADDRESS
E & B Hank	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91682

CERTIFICATE OF DEATH.

179 D 91682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 951 N. Franklin ST. 18 WARD)

2-FULL NAME Paul Levin

(a) RESIDENCE NO. 951 N. Franklin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 3 yrs. 3 mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Levin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Levin
(Address) 951 N. Franklin St

15 Filed NOV 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14th, 1924, to Nov 4th 1924, that I last saw h~~im~~ alive on Nov 4th, 1924, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Paul Brown, M. D.

11/4, 1924 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	11/5 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

D 91683

CERTIFICATE OF DEATH.

D 91683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 103 N. Virginia Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Fahey-

(a) RESIDENCE No. 103 N. Virginia Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cristina Stone Inspector

6 DATE OF BIRTH (month, day, and year) Nov 7/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter Stone Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. A. 886

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Albert Fahey-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Vernier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Henry H. Wittstadt 1531 W Lombard

15 Filed ....., 19.... Registered No. 1075 - 1924 Burial Permit Issued ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Nov 3, 1924.

that I last saw h[illegible] alive on Nov. 2, 1924

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver Portal

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 1 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. J. Stone, M. D.

1924 (Address) 677 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Nov 5th 1924

20 UNDERTAKER Henry H. Wittstadt Lombard 1531 W Lombard St ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91684

CERTIFICATE OF DEATH.

129 ✓ D 91684

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Virginia Ave ~~St.~~ WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison A. Woolford.

(a) RESIDENCE. No. 117 E. Virginia Ave ~~St.~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ✓ mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Woolford

6 DATE OF BIRTH (month, day, and year) Dec 24, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ~~min.~~
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) 1 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Jethro W. Woolford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Priscilla Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant Harrison A Woolford

(Address) [redacted] 2011 E Monument

15 Filed . 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

NOV 6 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 19..., to Nov 3, 19 24, that I last saw him alive on Nov. 2, 19 24, and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic.

(duration) ✓ yrs. 8 mos. ✓ ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ✓ yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon, M. D.

11/4, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 6 1924
20 UNDERTAKER	ADDRESS
George L. Smith	Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91685

CERTIFICATE OF DEATH.

187 D 91685

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen. Hosp. St., 8 WARD)

2-FULL NAME John J. Francis

(a) RESIDENCE No. 1729 N. Calhoun St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Francis

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Cement
(c) Name of employer Allis Co.

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Celia Francis
(Address) 1729 Calhoun St.

15 Filed NOV 6 1924, 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 5th cervical vertebra

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Struck in back by piece of cement mixer

(duration) ....yrs. ....mos. ....ds.

(Signed) Jas. T. Hennessy, M. D.
(Coroner.)

Nov. 4, 1924 (Address) 20 Saratoga Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Nov. 5 1924
20 UNDERTAKER	ADDRESS
Samuel Kennedy	1528

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-002

D 91686

CERTIFICATE OF DEATH.

D 91686

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2808 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Ritmiller

(a) Residence No. 2808 Elliott St., 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) Apr [redacted] 1922

7-AGE. 2 yrs. 6 mos. 13 ds. If [redacted] than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of Industry, business, or establishment in which employed (or employer). none

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Robert B. Ritmiller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Weiss

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant). Elizabeth Ritmiller

(Address) 2808 Elliott St. (Mother)

15- NOV 5 - 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 3rd 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1924 to Nov 3 1924

that I last saw her alive on Nov 3 1924

and that death occurred, on the date stated above, at 10.5 a. m.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) asphyxia (+ Uraemia)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [redacted] M. D.

10/4/, 1924 (Address) 1014 S. [redacted] Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cemetery — DATE OF BURIAL. Nov 5 1924

20-UNDERTAKER. Lilly + Zeiler — ADDRESS 1000 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91687

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Livingston

(a) RESIDENCE NO. 110 E Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13hr 45min			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland Gen Hosp

PARENTS

10 NAME OF FATHER Albert Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Pa

12 MAIDEN NAME OF MOTHER Betty Mannis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waynesboro Pa

14 Informant Albert Livingston
(Address) 110 W. Preston

15 Filed NOV 5 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 28 1924, 19 ... to Oct 29 1924, 19 ...

that I last saw h in alive on Oct 29, 1924, 19 ...

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Croup

Office

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1924, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hospital Grounds

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 91688 — X 185 D 91688

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lionel Gules

(a) RESIDENCE NO. 48 Market Place WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Jacob Gules

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Susan Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 5 - 1924, 19.. ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924, to Oct 29, 1924, that I last saw h—alive on Oct 29, 1924, and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Abscesses of thighs

Pyemia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct 27

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture

(Signed) Thos Harrold, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmell	Nov 5 1924
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91689

CERTIFICATE OF DEATH.

44 D 91689

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 William ST. 24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Dichelstiel

(a) RESIDENCE No. 1243 William ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? 68 yrs. 2 mos. 18 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Dichelstiel

6 DATE OF BIRTH (month, day, and year) Aug - 15 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer Continental Trust Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Dichelstiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Strauf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary J. Dichelstiel

(Address) 1243 William St

NOV 5 - 1924

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Nov 3, 1924, that I last saw him alive on Nov 2, 1924, and that death occurred, on the date stated above, at 7 40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

11/4/24 (Signed) C. B. Burton M. D.

(Address) 307 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 11/6 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1730 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91690

161-001

CERTIFICATE OF [illegible]

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 622 Hanover St (ST.) W (WARD)

2-FULL NAME Baby Barrett

(a) RESIDENCE NO. 622 Hanover St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or 30 min.
	7 Mo	Stillborn	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Hilda Ruhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hilda Ruhl
(Address) 622 Hanover.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 31/24, 19..., to Oct 31/24, 19...,

that I last saw her alive on Oct 31/24, 19...,

and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Henry F Holl, M. D.

Nov 3/ 19 24 (Address) 1702 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 3 - 1924 19

20 UNDERTAKER Commissioner Health,

ADDRESS

NOV 3 - 1924

1912

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 162 D 91691

1-PLACE OF DEATH Westport

Registered No.....

City of BALTIMORE: (No. 351 Patapsco St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lapp

(a) Residence No. 351 Patapsco St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 4 - 1924

7-AGE. .....yrs. .....mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Howard J. Lapp

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Elizabeth E. Gotwals

13-BIRTHPLACE OF MOTHER (city or town). Balto (State or Country), Md

14- (Informant)..... Howard J. Lapp

(Address)..... 351 Patapsco

NOV 5 - 1924 ROBERT F. KRAUSE Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1924, to Nov 5, 19.24, that I last saw h alive on Nov 4, 1924, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Prolonged labor

(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. H. Feinhard, M. D.

11/5, 1924 (Address) Masonic Apts. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill — DATE OF BURIAL. Nov 6, 1924

20-UNDERTAKER. John Cook — ADDRESS 202 E Pratt Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91692

CERTIFICATE OF DEATH.

11-606 D 91692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 E. Vincent St.: 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Keil Brown

(a) RESIDENCE. No. 226 E. Vincent St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle May Brown

6 DATE OF BIRTH (month, day, and year) 4/7/1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sewing Machine Hand

(b) General nature of industry, business, or establishment in which employed (or employer): Cake Bakery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John K. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Hundley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Floyd Brown

(Address) 226 E. Vincent

15 Filed NOV 5 - 1924 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1924, to Nov 4, 1924,

that I last saw him alive on Nov 4, 1924,

and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. Hilbs Hemming M. D.

11/5, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 8 1924
20 UNDERTAKER Harry H. Metzke	ADDRESS 1531 N. Smallwood St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91693

CERTIFICATE OF DEATH.

99 D 91693

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 717 N Charles St. 11 Ward)

2-FULL NAME Catherine MacWilliams Renshaw

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 717 N Charles St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? 81 yrs. 7 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widow or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Renshaw

6-DATE OF BIRTH (month, day and year) March 5 1843

7-AGE, 81 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Robert MacWilliams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Lanahan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant) Miss M. J. Sowers (niece)

(Address) Washington Apts.

NOV 5 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov-4-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Nov. 4, 1924, that I last saw h.e alive on Nov 3, 1924, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema,
Cardiac Dilatation,
Cerebral & general
arterio Sclerosis Several months

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. H. Thomson M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Hill Cemetery — DATE OF BURIAL, Nov 6, 1924

20-UNDERTAKER, STEWART & HOWEN COMPANY (WILLIAM E. HOWEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91694

CERTIFICATE OF DEATH.

D 91694

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Rennert ST., 4 WARD)

2-FULL NAME Harry R. Rogers

(a) RESIDENCE No. Cleveland Ohio ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hotel Manager
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant H B Rogers
(Address) Cleveland Ohio

15 Filed NOV 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said ..... (Coroner or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gled to death from wound in L & R Wrists

(duration) ... yrs. a few mos ... ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ... yrs. ... mos. ... ds.

(Signed) H B Jones, M. D.
(Coroner.)

Nov 5, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland Ohio

DATE OF BURIAL Nov 7 1924

20 UNDERTAKER W M Routson

ADDRESS 2238 N Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91695

CERTIFICATE OF DEATH.

71-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mrs. Lucille Watts

(a) Residence No. 1401 Division St. City St., Ward Virginia

(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1906

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS

10-NAME OF FATHER: do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): do not know

12-MAIDEN NAME OF MOTHER: do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): do not know

14- (Informant): Department Institution

(Address): 1401 Division St

15- Filed NOV 5 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11/3/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 24th 1924 to Nov. 3rd 1924, that I last saw her alive on Nov. 3rd 1924, and that death occurred, on the date stated above, at 8.30a m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Brain abscess

(Duration) yrs. 2 mos. ? ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of spinal

(Signed) Geo A Shwarz M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Nov 5 1924

20-UNDERTAKER: M Tarbyd Son — ADDRESS: 1822 N Wolfe

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91696

D 91696

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1752 Carswell ST., 9 WARD)

2-FULL NAME James Bunnin

(a) RESIDENCE NO. 1752 Carswell ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Catherin Bunnin

6 DATE OF BIRTH (month, day, and year) Sept. 14

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9 BIRTHPLACE (city or town) ..... (State or country) Tennessee.

PARENTS

10 NAME OF FATHER Daniel Bunnin

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Bessie Conway

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Tennessee

14 Informant Harry T. Morgan
(Address) 1752 Carswell st

15 Nov 5 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to November 3, 1924.

that I last saw him alive on November 3, 1924.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cancer 1 month 3
Carcinoma of root of the tongue and Left Jaw
about 8 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — — Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? at hospital

(Signed) F. Lacey Hutchcock M. D.

Nov 5 1924 (Address) 16 Forsyth ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov 6 1924

20 UNDERTAKER ..... ADDRESS

Geo. J. Rust 1735 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

D 91690 D 91697

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Rosa Frederick

(a) RESIDENCE NO. Perryman, Md. WARD E.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Femal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boarding House

(b) General nature of industry, business, or establishment in which employed (or employer) #

(c) Name of employer #

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER August Wittkowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Everlowsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 5 1924, 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1924, to Nov 4, 1924, that I last saw h alive on Nov 4, 1924, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Heart failure

Cancer gall bladder

(duration) ..... yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary)

Heart failure (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov. 1, '24

Was there an autopsy? Yes

What test confirmed diagnosis? Frozen section at operation

(Signed) [illegible], M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Lutheran	Nov 7 1924
20 UNDERTAKER	ADDRESS
Wm Leod & Son	N. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91698

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1201 Russell ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate E. Wernsdorfer

(a) RESIDENCE No. 1201 Russell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wernsdorfer

6 DATE OF BIRTH (month, day, and year) Aug 20 1872

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Wernsdorfer (Address) 1201 Russell

15 FILED NOV 5 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5- 1924

17

I HEREBY CERTIFY, That I attended deceased from August, 19 24, to Nov 4, 19 24,

that I last saw her alive on Nov 4, 19 24

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilfred Dramm, M. D.

, 19 (Address) 1207 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 11/6th 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mulberry

INFORMATION REQUESTED IN BLANK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Bks.

D 91699

HEALTH DEPARTMENT—CITY OF BALTIMORE

4-D 91699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Anna Voigt

(a) RESIDENCE NO. 2621 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of George B Voigt

6 DATE OF BIRTH (month, day, and year) Feb 8, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
69		6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Starty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl H Voigt
(Address) 2621 Barclay St

15 Filed ..... 19 Robert P. Harrison, Registrar
Burial Permit Clerk

NOV 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924, to Nov 3, 1924.

that I last saw her alive on Nov 3, 1924

and that death occurred, on the date stated above, at 5.26 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized Carcinoma

(duration) yrs. 2 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Reginald F. Johnston, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 6 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Mulb

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

D 91700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91700

CERTIFICATE OF DEATH.

X 66

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 3 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Brown

(a) RESIDENCE No. 808 E Pratt ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 50				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia Pa
(State or country)

PARENTS

10 NAME OF FATHER Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant William Murray
(Address) Bay View
Robert P. Harrison.

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholic Congestion of Brain

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute alcoholism

(duration) ..... yrs. ..... mos. 6 ds.

(Signed) James M Haulon, M. D.
(Coroner.)

Oct 18 192 4 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ... 192

20 UNDERTAKER Commissioner Health. — ADDRESS

Per Wm. E. Woodall

NOV 5 - 1924

Burial Permit Clerk

1924

1921 THE MORGUE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91701 (1756)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91701

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED No. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gail Stanley

(a) RESIDENCE No. 60 E Cumberland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Inst mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 19-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 5 1924, 19 Robert F. Harrison, 1917 Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Oct 25, 1924, that I last saw h— alive on Oct 25, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Autopsy, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Bureau of Health — ADDRESS

NOV 5 1924

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91702

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 Guyon Ave ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boquer

(a) RESIDENCE. No. 346 Guyon Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Eustach Boquer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margarite Kundahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margarite Boquer

(Address) 346 Guyon Ave

15 Filed NOV 5 1924 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h.. alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

"Premature birth"

.....

.....

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

11/4. 1924 (Signed) A. Hilbert Hemming, M. D.

(Address) 2000 Hallins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
HOPKINS HOSP	

20 UNDERTAKER Wm. E. Woodall

ADDRESS NOV 5 - 1924

Commissioner Health.

Bal. Wm. E. WOODALL

1916 Clerk

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91703

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2026 Brookfield Avenue St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Goss

(a) Residence No. 2026 Brookfield Avenue St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Robert Goss

6-DATE OF BIRTH (month, day and year) Oct. 13, 1845

7-AGE. 79 yrs. 0 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore County (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Absalom Wilson

11-BIRTHPLACE OF FATHER (city or town) Baltimore County (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Delilah Harvey

13-BIRTHPLACE OF MOTHER (city or town) Baltimore County (State or Country), Maryland

14- (Informant) Miss Aimee D. Goss

(Address) 2026 Brookfield Ave.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

~~1924~~ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1922, to Nov. 4, 1924

that I last saw h. alive on Nov. 3, 1924

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Valvulitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Stanford McKelvey, M. D.

11-4-1924 (Address) 1609 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem. DATE OF BURIAL, Nov 7, 1924

20-UNDERTAKER. Emil L. Cook ADDRESS 1003 N. Gilmor St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

CV5

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91704

CERTIFICATE OF DEATH.

179 D 91704

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2337 Donohue Court ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karolina . Lamparska

(a) RESIDENCE NO. 2337 Donohue Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John . Lamparski

6 DATE OF BIRTH (month, day, and year) Dec. 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Edward. Lamparski Son.
(Address) 2337 Donohue Court

15 NOV 5 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1924

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1924, to November 5 24.
that I last saw h[illegible] alive on November 5, 1924
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Casimir Kunkowski, M. D.

, 19 (Address) 2539 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Nov. 8 1924

20 UNDERTAKER John M. Kelly ADDRESS 1803 Bank St

WARNING—REGISTRATION BLANKS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91705

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 91705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 S. Washington ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine . Gudryan

(a) RESIDENCE NO. 207 S. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant William . Czerwinski

(Address) 207 S. Washington Street

15 Filed NOV 5 - 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1924, to Nov 5, 1924, that I last saw h[illegible] alive on Nov 5, 1924 and that death occurred, on the date stated above, at 12-05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Maxwell M. D.

Nov 5, 1924 (Address) 207 S Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Nov. 7 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

D 91706

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 871 Harlem ave Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Thomas Felton

(a) Residence No.... 871 Harlem ave St.... Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If ~~married,~~ widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Nannie Felton

6-DATE OF BIRTH (month, day and year) Aug - 4 - 1879

7-AGE, 45 yrs. 3 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer) Ø

(c) Name of employer

9-BIRTHPLACE (city or town) Norfolk (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Benjamin Felton

11-BIRTHPLACE OF FATHER (city or town) Norfolk (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Mariah Morris

13-BIRTHPLACE OF MOTHER (city or town) Norfolk (State or Country), Virginia

14- (Informant) James Felton

(Address) 910 N. Carey St.

NOV 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov - 4 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov - , 1920, to Nov - 4 1924

that I last saw him alive on Nov - 3, 1924

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Endocarditis -

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis -

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no -

What test confirmed diagnosis? Autopsy -

(Signed) Dan Franklin M. D

11/5, 1924 (Address) 122 W Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Auburn	Nov 7, 1924
20-UNDERTAKER. John H. Toadvine	ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91707

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 90 Lexington ST., 23 WARD)

2-FULL NAME John E. Russell

(a) RESIDENCE NO. 917 Lexington ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Russell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Montgomery Co, Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Annie Russell
(Address) 917 Lexington St

15 Filed NOV 6 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1924, to Nov 4, 1924, that I last saw ~~living~~ alive on Nov 4, 1924, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. H. Smith, M. D.

Nov 5, 1924 (Address) 109 N. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 7 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Hanover St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91708

101-001D 91708

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tucker

(a) RESIDENCE NO. 926 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) A.A. Co (State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible] (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country)

14 Informant Wesley Tucker (Address) 928 Druid Hill ave

15 Filed NOV 5 - 1924, 19 ROBERT R. KRAUTER, Burle Parrall Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Nov. 3, 1924, that I last saw her alive on Nov. 3, 1924, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch — DATE OF BURIAL Nov 6 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sherman Jobes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91709

CERTIFICATE OF DEATH.

101-001

D 91709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 W Monty, St.: 27 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sherman Jobes

(a) RESIDENCE. No. 630 W Monty St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-30-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Henry Jobes

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER Elnora Clash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant Elnora Jobes

(Address) 630 mon[illegible]

15 [illegible]

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924 to Nov 4, 1924

that I last saw h[illegible] alive on Nov 3, 1924

and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

(duration) yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) [illegible] M. D.

(Address) 712 S. Mark St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 6 1924

20 UNDERTAKER John H. Tradin

ADDRESS 1027 Hanover Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91710

CERTIFICATE OF DEATH.

90 D 91710

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. West Baltimore Ave near Mulford ST., 25 WARD)

2-FULL NAME Mary Ella Chambers

(a) RESIDENCE NO. 2 West Baltimore Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Chambers

6 DATE OF BIRTH (month, day, and year) Dec 27, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Henry H Jonas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W Chambers (Address) 2 West Balt Ave

15 NOV 6 - 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Nov 4, 1924 that I last saw h alive on Nov 2, 1924 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. McKee Taylor M. D.

Nov 5 1924 (Address) 1320 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Nov 6 1924

20 UNDERTAKER W. H. Cook ADDRESS 502 E Madison

D 91711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C 91711

1-PLACE OF DEATH

City of BALTIMORE: (No. Ferrar Foot of Light St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wasily Roshenvich

(Residence in Baltimore: No. 407 Grandall St. St.; 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE. 29 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer). Lab.

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Stephan

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephan Roshenvich

(Address) 407 Grandall

15- NOV 6 - 1924 Filed ..... 192.. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 4 (Month) (Day) 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Ruhig M. D. (Coroner.)

Dec 5 192.4 (Address) 1639 Penn

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Nov 6 192.4

20-UNDERTAKER. John A. Gretkowski Jr ADDRESS 425 S. Paca St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THESE RECORDS FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91712

CERTIFICATE OF DEATH.

89 D 91712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3026 Belmont Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cockburn

(a) RESIDENCE NO. 3026 Belmont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? 2 yrs. 7 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Doubella Elizibeth Cockburn

6 DATE OF BIRTH (month, day, and year) Dec-8-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Newcastle on Tyne England.

PARENTS

10 NAME OF FATHER James Cockburn

11 BIRTHPLACE OF FATHER (city or town) Berwyck on Tweed (State or country) England.

12 MAIDEN NAME OF MOTHER Doubella Cockburn

13 BIRTHPLACE OF MOTHER (city or town) Berwyck on Tweed (State or country) England.

14 Informant Mary Jorgensen

(Address) 3026 Belmont Ave.

15 NOV 6 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-2- , 1924 , to 11-3- , 1924 , that I last saw him alive on 11-3- , 1924 , and that death occurred, on the date stated above, at 10:25 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. — mos 26 hours

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) Chester Riland, M. D.

11-4, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 11-6- 1924

20 UNDERTAKER H. Brauning Son

ADDRESS 617 N Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 91713

CERTIFICATE OF DEATH.

D 91713

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 N. Fort Av. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ruby E. Splitgerber.

(a) Residence No. 207 N. Fort Av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.)

8a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 7, 1924

7-AGE. ..... yrs. 1 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Herman Splitgerber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Augusta W. Palinske

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) Herman Splitgerber

(Address) 207 N. Fort Av.

15-

NOV 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 4 or 5 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 or 5 1924 to Nov 4 or 5 1924

that I last saw him alive on Nov 4 or 5 1924

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) S. H. Jones, M. D.

Nov 5, 1924 (Address) 1501 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Forest Lawn Cem. Lawn.

DATE OF BURIAL, Nov 6 1924

20-UNDERTAKER. T. Leman

ADDRESS 32 N Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91714

CERTIFICATE OF DEATH.

D 91714

1-PLACE OF DEATH

City of BALTIMORE: (No. 1913 Harlem Ave. 16 Ward)

Registered No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James G. Leake

(a) Residence No. 1913 Harlem Av St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Carrie E. Leake

6-DATE OF BIRTH (month, day and year) Jan 16, 1849

7-AGE, 75 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Luke A. Leake

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary St. Victor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Mrs. Carrie E. Leake

(Address) 1913 Harlem Ave

15-

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) NOV 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Nov 4, 1924 that I last saw him alive on Nov 2, 1924 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Drunk 5

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Park Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tumor & Section

(Signed) Jno H. Deaver, M. D.

NOV 5 19 1924 (Address) 2105 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park

DATE OF BURIAL, NOV 7 1924, 19....

20-UNDERTAKER, Geo W Little

ADDRESS 2700 EDMONDSON AVE.

NO. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91715

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 W. Lanvale St. 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Walker

(a) RESIDENCE. No. 2043 W Lanvale St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? ~~yrs.~~ ~~mos.~~ ~~ds.~~

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

~~3 SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. Walker

6 DATE OF BIRTH (month, day, and year) April 1st 1872

7 AGE Years 52 Months 7 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Quesperund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant John H. Walker

(Address) 2043 W. Lanvale St

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to Nov 5, 1924.

that I last saw h.. alive on Sept 20, 1924.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Regurgitation

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia, Chronic Anemia

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Roy D. McCleary M. D.

11/5, 1924 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Nov 7 1924

20 UNDERTAKER H. B. Shepherd ADDRESS 1850 W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Emrich

D 91716

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-006 91716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 349 Fort Hill Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Emrick

(a) RESIDENCE NO 349 Fort Hill Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Daisy Miyatta (Address) 349 Fort Hill Ave.

15 NOV 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd - 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. B. Norton, M. D.
(Coroner.)

Nov. 3rd, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side or additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tramients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Nov 6th 1924

20 UNDERTAKER 703 Hopkins Pl. & 2256 Eutaw Ave — ADDRESS

CAUTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D 91717

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 Patapsco Ave. St. Helena 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H. Cordrey Jr.

(a) Residence No. 312 Patapsco Ave., St. Helena St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~[illegible]~~ Mary E Cordrey.

6-DATE OF BIRTH (month, day and year) Oct. 19, 1889

7-AGE. 35 yrs. mos. 15 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Structural

(b) General nature of industry, business, or establishment in which employed (or employer). Iron Worker

(c) Name of employer. Bethlehem Steel Co.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Samuel H. Cordrey Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Delaware

12-MAIDEN NAME OF MOTHER, Catherine Doughtery

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Samuel H. Cordrey

(Address) 429 F. St. Sparrows Pt.

NOV 6 - 1924

19- ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 24, 19 24 to Nov 4th, 19 24

that I last saw h. alive on Nov 3rd 19 24

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank E Eldridge M. D.

Nov 5th, 1924 (Address) Sparrows Point Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

20-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Nov 7, 1924
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91718 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

46 D 91718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt. general Hospital

CITY OF BALTIMORE: (No. Rayner ave & Druid Park St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Herring.

(a) RESIDENCE No. 32 north Fort Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Charles E. Herring.

6 DATE OF BIRTH (month, day, and year) May 8, 1881

7 AGE	43 Years	Months 5	Days 28	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Kunsdell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Koenstie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Chas E. Herring 32 N. East Ave

15 Filed NOV 6 - 1924 16 ROBERT R. KRAUSE, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5. 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2. 1924. to Nov. 5 1924. that I last saw h alive on Nov. 5. 1924. and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri, with metastasis

— (duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 4-8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 4. 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operation

(Signed) Clement R. Mencel. M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr. Lawrence Cem.	Nov 8 1924
20 UNDERTAKER Chas. Johnson Jr.	ADDRESS W. Lexington

Cor.—1-12-23—M&T—100 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91719

CERTIFICATE OF DEATH.

90 D 91719

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Aisquith ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne Keleher

(a) RESIDENCE NO. 1819 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Keheler

6 DATE OF BIRTH (month, day, and year) June 22/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Owen Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Gormley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Maurice Keheler (son)
(Address) Providence [illegible]

15 [illegible]

NOV 6 - 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Probably Valvular

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. T. Callen, M. D. (Coroner.)

11/6/24 192 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL Nov 7 1924

20 UNDERTAKER Ralph J. Sumner Inc — ADDRESS 1442 W Baltimore

IMPORTANT: This certificate should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91720

CERTIFICATE OF DEATH.

100-902 D 91720

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 7101 E. Fairmount Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bremer

(a) Residence No. 7101 E. Fairmount Ave St., 6 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Oct 16-1924

7-AGE. ... yrs. ... mos. 19 ds. If LESS than 1 day ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town): Balto.
(State or Country): Md.

PARENTS

10-NAME OF FATHER: Henry Bremer

11-BIRTHPLACE OF FATHER (city or town): Germany
(State or Country):

12-MAIDEN NAME OF MOTHER: Mary Held

13-BIRTHPLACE OF MOTHER (city or town): Balto.
(State or Country): Md.

11- (Informant): Henry Bremer
(Address): 7101 E. Fairmount Ave

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 4-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 3, 1924 to Nov 5 1924

that I last saw h[illegible] alive on Nov 5 1924

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Capillary Bronchitis

(Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? ?? Date of —

Was there an autopsy? ??

What test confirmed diagnosis? —

(Signed) A Weinberg M. D

Nov 6 1924 (Address) 14 E Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, Nov. 6, 1924

20-UNDERTAKER: Lilly & Zeiler — ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91721

CERTIFICATE OF DEATH.

'90 D 91721

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Donnell ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Schorr

(a) RESIDENCE NO. 3207 Donnell Pl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schorr

6 DATE OF BIRTH (month, day, and year) Sept-29 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ferdeinand Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Schorr

(Address) 3207 Donnell Pl

15 Filed ....., 19.... ROBERT P. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 - 1924

17

I HEREBY CERTIFY, That I attended deceased from July, 1921, to Nov 4 - 1924, that I last saw h[illegible] alive on Nov. 3 - 1924, and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. arteris - Sclerosis

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J Dandor, M. D.

, 19 (Address) 3035 Donnell Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Nov. 7 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 4038 Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91722

CERTIFICATE OF DEATH.

D 91722

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3910 Hawthorne Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jacob Spoerer

(a) Residence No..... 3910 Hawthorne Ave. St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Spoerer

6-DATE OF BIRTH (month, day and year) Apr. 18, 1877

7-AGE, 47 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Partner in Carl

(b) General nature of industry, business, or establishment in which employed (or employer)... Spoerer Sons's Co.

(c) Name of employer..... Auto Mfg. Company

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Carl Spoerer

11-BIRTHPLACE OF FATHER (city or town)... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Charlotta Scheidt

13-BIRTHPLACE OF MOTHER (city or town)..... Germany
(State or Country),

14-
(Informant)..... Mrs. Katie Spoerer
(Address)..... 3910 Hawthorne Ave.

15-
Filed..... NOV 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to Nov 5, 1924, that I last saw h... alive on Nov 4, 1924, and that death occurred, on the date stated above, at 4.55 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1924

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin B. Reinhardt M. D.

11-5-19 24 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, Nov. 7, 24

20-UNDERTAKER: Joseph L. Cook ADDRESS 1003 N. Bond St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91723

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 91723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1041 William St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Frank J. Ranneberg Jr

(a) Residence No... 1041 William St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 19 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 17/24

7-AGE. ... yrs. ... mos. 19 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank J Ranneberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Vina Bruto

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York N.Y.

14- (Informant) Mrs. Ranneberg

(Address) 1041 William St

15- NOV 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 5/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 19 24 to Nov 5 19 24

that I last saw h[illegible] alive on Nov 5 19 24

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R.E.K. Campbell M. D.

Nov 5, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cem	Nov 2, 1924
20-UNDERTAKER. John Ellis	ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91724

CERTIFICATE OF DEATH.

D 91724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Dank

(a) RESIDENCE NO. 1102 E. Eager St. ST., X WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Annie M. Dank

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1867.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	1.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Wm. E. Rath Co.

(c) Name of employer Cigarstore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian Dank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dinah Germain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Dank (Address) 803 Eager St

15 Filed ..... 19 ..... JOHN F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5th. 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30. 1924. to Nov. 5. 1924.

that I last saw him alive on Nov. 5 1924

and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH* was as follows:

General weakness

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Atony of Stomach

(duration — yrs 6 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. J. Siebold, M. D.

, 19 (Address) 1 Division & Smith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL Nov 7 1924

20 UNDERTAKER John Ellerich

ADDRESS Edison

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91725

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2101-N-Charles St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bastable Forbes

(a) Residence No. 2101-N-Charles St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 82 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred T. Forbes

6-DATE OF BIRTH (month, day and year) about 1842

7-AGE, About 82 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Warrenton Virginia

PARENTS.

10-NAME OF FATHER Gilbert C. Bastable

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Caroline Ashby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Scott G. Woolfe (cousin)

(Address) 2418 St. Paul St.

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 5, 1924, to Nov 5, 1924, that I last saw h[illegible] alive on Nov 4, 1924 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

due probably to Carcinoma

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No What test confirmed diagnosis? Vomitus Blood

(Signed) Otto T. Pleasants M. D.

Nov 6, 1924 (Address) 2105 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Nov 6, 1924

20-UNDERTAKER, Stewart & Mowell — ADDRESS 108 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC should be carefully supplied. AGE should be stated E In plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91726

HEALTH DEPARTMENT—CITY OF BALTIMORE

13 D 91726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital
Bay View Asylum

City of BALTIMORE (No.) St., 13 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Waters

(a) Residence No. 2428 Etting Street St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886.

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Loyd. Waters

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

11- (Informant) Hospital Records

(Address) Bay View Hospital

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-4-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 9- 1924. to Nov 4 1924.

that I last saw h[illegible] alive on Nov 4 1924

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Right Maxillary Antrum & Extension into Nose & mouth - & Metastases to Cervical Lymph Glands (a) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. Tests.

(Signed) Jr. O'Champe Jr. M. D.

Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Mountain Cemetery Hospital to

DATE OF BURIAL. Nov 7 1924

20-UNDERTAKER. Chas. E. Hemberger

ADDRESS Fallston Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

91727

HEALTH DEPARTMENT--CITY OF BALTIMORE

38 D 91727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Brannon

(a) Residence No. 117 Toney Road, Cherokee Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: James G. Brannon

6-DATE OF BIRTH (month, day and year): 1857

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14-(Informant) Municipal Hospital Records
(Address)

15-Filed NOV 6 1924 ROBERT A. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-4-24

17- I HEREBY CERTIFY, That I attended deceased from 6-1, 1922 to 11-4, 1924

that I last saw h[illegible] alive on 11-4, 1924

and that death occurred, on the date stated above, at 9.55 a. m.

The CAUSE OF DEATH* was as follows:

C. N. S. Syphilis (Tabes Dorsalis)

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronco-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude C. Grace, M. D.

11-4, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bem — DATE OF BURIAL: Nov. 6th 1924

20-UNDERTAKER: J. A. Moran — ADDRESS 3000 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--1-12-23—M&T—100 Bks.

D 91728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002 D 91728

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John PONIATOWSKI

(a) RESIDENCE No 923 S. Harris Alley ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 27/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jas. Poniatowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Tillie Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant James Poniatowski
(Address) 923 S. Harris Alley

15 NOV 6 - 1924 ROBERT R. KRAUTER Registrar

Racial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rt. thigh severed &rt forearm crushed
Street car accident (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Keller, M. D.
(Coroner.)
Nov 4/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Nov. 6. 1924
20 UNDERTAKER	ADDRESS
Leppley & Wadsworth	1000 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 91729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St. WARD)

2-FULL NAME Mrs. Elizabeth Brown

(a) RESIDENCE NO. 416 E. Lanvale St St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli. H. Brown

6 DATE OF BIRTH (month, day, and year) Mch. 29, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John Brenibold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Co.

12 MAIDEN NAME OF MOTHER Indiana Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Co.

14 Informant Mrs Elizabeth Brown

(Address) 416 E Lanvale St

15 Filed NOV 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1924, to Nov. 6, 1924, that I last saw her alive on Nov. 6, 1924, and that death occurred, on the date stated above, at 5:25 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus with Gangrene

Arteriosclerosis ; Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac trouble -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11/5/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Nov 8 1924

20 UNDERTAKER William Cook — ADDRESS SOLE Nott. Av

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91730

CERTIFICATE OF DEATH.

101-D 91730

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 North Charles ST., 11 WARD)

2-FULL NAME Anne Dorothy Gordon Lovell

(a) RESIDENCE NO. 829 N. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
femal	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6 of 4-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Anderson Lovell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Natchez, Miss

12 MAIDEN NAME OF MOTHER Anne Campbell Gordon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Charlottesville, Va.

14 Informant Widow Nelson
(Address) 42 Preston St.

15 Filed NOV 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1924, to Nov. 5th, 1924, that I last saw h[illegible] alive on Nov 5th, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Encephalo-Meningitis

(duration) 19 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm. M. Lucas, M. D.

, 19 (Address) 42. Preston St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Nov 7 1924

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91731

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09

D 91731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Dallas ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elihu Stockett

(a) RESIDENCE NO. 820 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	11 mo.	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edw A. Stockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Mary L Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Lillie L. Stockett

(Address) 820 N. Dallas St.

NOV 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-1924

17 I HEREBY CERTIFY, That I attended deceased from 11-1-1924, to 11-4-1924, that I last saw him alive on 11-4-1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11-5-1924 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemtry — DATE OF BURIAL Nov 7 1924

20 UNDERTAKER Robert F Williams — ADDRESS 1515 Mc Elderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91732

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 851 Greenmount ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Fannin

(a) Residence No. 805 Greenmount ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widow~~ Widowed, or Divorced, (Write the word.)

5a-If ~~married, widowed, or divorced~~, (HUSBAND of ~~the~~) WIFE of John Fannin

6-DATE OF BIRTH (month, day and year) ~~Not known.~~ 1867

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Philip Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Portland

12-MAIDEN NAME OF MOTHER, Kate Burke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) E J Fanning

(Address) 1938 E Lafayette ave

15- NOV 6 - 1924 AGNES M. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1924 to Nov 3 1924

that I last saw h~~e~~r alive on Nov 3 1924,

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General carcinomatosis (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1 year ago

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. J. Rountree M. D.

11/5 1924 (Address) 733 S Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral	11/7, 1924
20-UNDERTAKER.	**ADDRESS**
E J Fanning & Son 1938	E Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91733 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91733

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sarah Bell

(a) Residence No. 2024 McCulloh St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1866

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14- (Informant) Municipal Hospital Records

(Address)

15- NOV 6 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-4-24

17- I HEREBY CERTIFY, That I attended deceased from 11-16, 1923, to 11-4, 1924, that I last saw h[illegible] alive on 11-4, 1924, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(Duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude G. Draper, M. D.

11-4, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL, Nov 6, 1924

20-UNDERTAKER: Samuel Hawley ADDRESS 1716 Bell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91734

CERTIFICATE OF DEATH.

94001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2077 Woodbury Ave ST., 13 WARD)

2-FULL NAME William Henry Morgan.

(a) RESIDENCE No. 2077 Woodbury Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Jane Morgan

6 DATE OF BIRTH (month, day, and year) Aug 2 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hertford, (State or country) N. C.

PARENTS

10 NAME OF FATHER Timothy Morgan.

11 BIRTHPLACE OF FATHER (city or town) unknown, (State or country)

12 MAIDEN NAME OF MOTHER Miley Raiper.

13 BIRTHPLACE OF MOTHER (city or town) unknown. (State or country)

14 Informant George P. Kimball
(Address) 2077 Woodbury ave

15 NOV 6 - 1924 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1924, to Nov. 6, 1924, that I last saw h.. alive on Nov. 5, 1924 and that death occurred, on the date stated above, at 4:40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Arteriosclerosis, Central apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. H. Mueller, M. D.

. 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Nov 8, 1924

20 UNDERTAKER Walter R. McNamee

ADDRESS 4114 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91735

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1648 Harwick ave St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Vondersmith

(a) RESIDENCE. No. 1648 Harwick ave St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? 4 yrs ✓ mos. ✓ ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	✓	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Danl. C. Vondersmith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Hooker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mabel Stamp
(Address) 1648 Harwick ave.

15 Filed ..... 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1924, to November 5, 1924, that I last saw h[illegible] alive on November 5, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease (rheumatic) — mitral & aortic insufficiency

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Bronchitis, acute. Cardiac decompensation auricular fibrillation (duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lawson Hilkins, M. D.

Nov 6 1924 (Address) 1014 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Nov 8 1924
20 UNDERTAKER	ADDRESS 1944
Harry W Ehlen	W. North Ave

9V6 - 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2944 Greenmount ave St.) 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary V Conner

(a) Residence No. 2944 Greenmount ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of William F Conner

6-DATE OF BIRTH (month, day and year) Nov 30 1854

7-AGE, 69 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Kent Co Md

PARENTS.

10-NAME OF FATHER, Thomas Hewitt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER, Henrietta Smallwood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Kent Co Md

14- (Informant) John A Conner

(Address) 2944 Greenmount ave

15- Filed NOV 6 1924 192.... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1924 to Nov 5th 1924 that I last saw ~~her~~ alive on Nov 5th 1924 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebral Hemorrhage

Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo W Mengert M.D.

(Address) 19 11/5/24 1419 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov 8th 1924

20-UNDERTAKER, George Schilling & Sons ADDRESS 1146 E Monument St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

D 91737

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

D 91737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Tuam Coll

(a) Residence No. Raleigh & Reay St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/4/24

7-AGE. ..... yrs. One mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md.
(State or Country).

PARENTS:

10-NAME OF FATHER. Louis J. Coll.

11-BIRTHPLACE OF FATHER (city or town) Bellegore
(State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Mary Trower
Don't Know

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country). Don't Know

14-

(Informant).....

(Address) St. Agnes Hosp.

15-Filed NOV 6 1924

Robert P. Harrison,
192
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/5/24

17- I HEREBY CERTIFY, That I attended deceased from 11/4 1924 to 11/5 1924, that I last saw her alive on 11/5 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Dystocia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jordan J. Battle M. D

, 19 (Address) Reay - Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 6, 1924
20-UNDERTAKER. E A Wendfeld	ADDRESS 501 E 22

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

NOV 6 - 1924

Spec.—1-10-21—M&T—1500 Bks.

D 91738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 91738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., H WARD)

2-FULL NAME Baby girl. Bittner

(a) RESIDENCE NO. Mercy Hospital ST., city WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ds. 6 How long in U. S., if of foreign birth? ~~yrs.~~ ~~mos.~~ 6 ds.

(If not a resident give city or town and State) Woodlawn Md

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/30/24.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none Infant

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Mercy Hospital

PARENTS

10 NAME OF FATHER Earl R. Bittner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lock Haven Pa

12 MAIDEN NAME OF MOTHER Beatrice Lemon

13 BIRTHPLACE OF MOTHER (city or town) Brockwell (State or country) Pa.

14 Informant Mercy Hospital Record (Address)

15 Filed Nov 6 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5 1924

17

I HEREBY CERTIFY, That I attended deceased from 10/30, 1924, to 11/5, 1924, that I last saw h/ 12:20 Pm. alive on 11/5, 1924, and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Prematurity —

Respiratory, Interna Neonatorum —

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Respiratory —

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) K. W. Hallen, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 7 1924

20 UNDERTAKER Harry H. Almacost

ADDRESS 4204 Ridgewood Ave

Spec.—1-10-21—M&T—1500 Bks.

D 91739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Reisterstown Road above Liberty Heights Ave.

CITY OF BALTIMORE: (No. Britton Hall Apts 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignaz M. Regner

(a) RESIDENCE NO. Britton Hall Apts WARD Rochester, N.Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Regner

6 DATE OF BIRTH (month, day, and year) Mch. 23, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Greif Bros. 086

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs. Leonard Regner

(Address) Britton Hall Apts

15 Filed OV-6 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Nov. 5, 1924.

that I last saw h alive on Nov. 5, 1924

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Crisfield, Md.

Did an operation precede death? No. Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Signs & Symp.

(Signed) Dr Julius D. Holofarmer, M. D.

, 19 (Address) Britton Hall.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem.	11/7/1924
20 UNDERTAKER	ADDRESS
David Sondheim	118-20 W. Mt. Royal Ave.

WARNING—RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91740

160 D 91740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen'l Hosp. ST., 12 WARD)

2-FULL NAME John Edward Smith.

(a) RESIDENCE NO. 2021 Maryland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant - none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md - (State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) Phila. Pa. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Magnus

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Sarah Magnus

(Address) 2021 Md. Ave Johns

15 NOV 7 1924 ROBERT R. KRAUTER, Death Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1924, to Nov. 5, 1924.

that I last saw him alive on Nov. 5, 1924

and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) unknown - yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms.

(Signed) J. E. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner of Health,	ADDRESS

NOV 6 - 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

336

Cor.—1-12-25—M&T—100 Bks.

D 91741

HEALTH DEPARTMENT—CITY OF BALTIMORE

114 D 91741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1464 N. Biddle St., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Missouri Decator

(a) RESIDENCE NO. 1104 N. Stockton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) March 6, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer Easton, Md.

9 BIRTHPLACE (city or town) (State or country) Wesley Dicherson

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Filgaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robert Summers
(Address) 1464 W. Biddle St.

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. gastro enteritis

(duration) ..... yrs. ..... mos. 1 hr. ds.

CONTRIBUTORY (Secondary) dc. Dil. of heart.

(duration) ..... yrs. ..... mos. 5 months ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 5, 1924 (Address) 280 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 7 1924
20 UNDERTAKER	ADDRESS
Sam'l. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91742 — 114 — D 91742

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1736 N. Monroe St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Caplan

(Residence in Baltimore: No. 1736 N. Monroe St. St.; yrs., 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, about (Month) (Day), 1856 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Furniture Dealer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon Caplan

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Hyman Caplan

(Address)..... 1736 N. Monroe St

15- Filed NOV 7 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 6, (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... acute gastro-enteritis

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Def. of heart

..... (Duration) ..... yrs. ..... mos. 5 minutes ds.

(Signed) ..... J. J. Hennessy M. D. (Coroner.)

Nov. 6, 1924 (Address) 1802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herring Run	11/7, 1924
20-UNDERTAKER Jack Levin	ADDRESS 1409 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91743

CERTIFICATE OF DEATH.

31

D 91743

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Orleans ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Stewart

(a) RESIDENCE. NO. 1535 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER James H Steward

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Wallace

13 BIRTHPLACE OF MOTHER (city or town) Annapolis Md
(State or country)

14 Informant James H Steward father
(Address) 1535 Orleans St.

15 NOV 7 1924 ROBERT R. KRAUTER Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 1924 to Nov 6 1924.

that I last saw him alive on Nov 5 1924.

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gatrey M. D.

11/6 1924 (Address) 429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mayothy chuch a.a. co Md	nov 8 1924
20 UNDERTAKER	ADDRESS
Edward Brayor	orleans

Cor.—1-12-23—M&T—100 Bks.

Medelis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91744

CERTIFICATE OF DEATH.

90 D 91744

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 S Paca ST., 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Medelis

(a) RESIDENCE No 513 S Paca st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of John Medelis

6 DATE OF BIRTH (month, day, and year) June 14 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Sieman Skalandis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER ~~Anna~~ Noxon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant John Medelis
(Address) 513 S. Paca Street

15 NOV 7 1924 ROBERT A. KRAUTH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. Don't Know mos. ds.

CONTRIBUTORY (Secondary) Lagrip & Bronchitis

(duration) yrs. 1 mos. ds.

(Signed) W K Gamble, M. D. (Coroner.)

Nov 6 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 8 1924
20 UNDERTAKER	ADDRESS
John Gzebiauckas	425 S. Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 91745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1628 N. Bond St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Victor

(a) Residence No. 1628 N. Bond St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leopold A. Victor

6-DATE OF BIRTH (month, day and year) July 8-1859

7-AGE. 65 yrs. 3 mos. 29 ds. | If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Samuel Waletrum

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Catherine A. Shreck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto.

14- (Informant) Mr. Waletrum

(Address) 1628 N. Bond st

15- Filed NOV 7 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 6-1924

17- I HEREBY CERTIFY, That I attended deceased from 8-9-23 19.. to 11.6. 24 19..

that I last saw h alive on 11.5.24 19..

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical- Microscopic

(Signed) Philip B. Lawler M. D

11.6. 19.. (Address) 1432 William St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cem Ass Co	Nov 8 1924
20-UNDERTAKER	ADDRESS
Isaac F. Faust & Son	1180 W. Mt Royal Ave

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91746

CERTIFICATE OF DEATH.

49

D 91746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME Charles Rowland

(a) RESIDENCE No. 17 Hanto Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed NOV 7 1924 ROBERT P. KRAUTER Registrar

1926

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-25, 1924, to 11-3, 1924, that I last saw him alive on 11-3, 1924 and that death occurred, on the date stated above, at 7:35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude G. Drane, M. D.

11-4, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

NOV 7 - 1924

Per Wm. F. WOODALL

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

336

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91747

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2622 Lydia South Way ST.: 15 WARD)

2-FULL NAME Minnie L Miller

(a) RESIDENCE. No. 2622 Lydia Southway ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore St

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1924, to Oct 7, 1924, that I last saw h alive on Oct 7, 1924, and that death occurred, on the date stated above, at 8 a, m.

The CAUSE OF DEATH* was as follows:

~~Hypostatic~~ Hypostatic Pneumonia.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Harvey Lakey M. D.

11/7, 1924 (Address) 2027 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	11/7 1924

20 UNDERTAKER Jack Levis 1439 E Baltimore

ADDRESS

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91748

CERTIFICATE OF DEATH.

31

D 91748

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

2-FULL NAME Mary McKenna

(a) RESIDENCE No. 134 S. Poppleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Wm McKenna

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-14 1924, to 11-4 1924,

that I last saw her alive on 11-4 1924

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. (History) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude E. Brace, M. D.

11-5. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 8 1924

20 UNDERTAKER Geo. E. Lawson & Son ADDRESS 1 E. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91749 HEALTH DEPARTMENT—CITY OF BALTIMORE

7/24 D 91749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Marine Hospital No 1. Baltimore, Md.

CITY OF BALTIMORE: (No. ..... St., 17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Leiter

U S Marine Hospital No 1.

(a) RESIDENCE NO. 319 Pine St Phila Pa St., ... Ward 1

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? 12 yrs. mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Seaman

(c) Name of employer U.S. Pathfinder

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Un known

11 BIRTHPLACE OF FATHER (city or town) Un known (State or country)

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) Un known (State or country)

14 Informant Self.

(Address) .....

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Nov. 5, 1924, that I last saw him alive on Nov. 5, 1924, and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart, acute

Contributory Cause,

Acute Indigestion 1 hour

Cholangitis acute (duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? On board.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings and laboratory test

(Signed) W. H. Foster, M. D.

Surgeon in Charge

19 , 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 7 1924
20 UNDERTAKER S. Levin & Bro.	ADDRESS 1127 E. Balto. St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 91750

D 91750

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 400 N Fulton Ave St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Madelene Benning.

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St. yrs. 53 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Febry 8, 1838 (Month) (Day) (Year)

7 AGE: 86 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Switzerland In Baltimore since 1871

PARENTS

10 NAME OF FATHER: Nicholas Cellars

11 BIRTHPLACE OF FATHER (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Elizbeth Koleker.

13 BIRTHPLACE OF MOTHER (State or country): Switzerland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy

(Address) 400 N Fulton Ave

15 NOV 7 1924 ROBERT F. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 6. (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Nov 6 1924.

that I saw her alive on Nov 5 1924.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 3. yrs. ✓ mos. ✓ ds

Contributory (SECONDARY)

(Duration) ✓ yrs. 3 mos. ✓ ds.

(Signed) George C Shannon M. D.

Nov 6, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mount Olivet Cem. DATE OF BURIAL: November 10 1924

20 UNDERTAKER: George J Smith ADDRESS: 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91751

CERTIFICATE OF DEATH.

1 90

D 91751

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2104 Railroad ave Mt Union St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Raymond Kelly

(a) Residence No. 2104 Rail Road ave Mt Union St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) ~~WIFE~~ of Addie Kelly

6-DATE OF BIRTH (month, day and year) June 8/1893

7-AGE. 31 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Glass fac

(b) General nature of industry, business, or establishment in which employed (or employer). worker

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). md

PARENTS.

10-NAME OF FATHER. William C. Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country). md

12-MAIDEN NAME OF MOTHER. Anna B. Creamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). md

14-

(Informant). Anna B. Creamer

(Address). Mt Winans

15-

Filed. NOV 7 1924 ROBT. E. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 7/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1924, to Nov 7, 1924, that I last saw him alive on Nov 6, 1924, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Insufficiency

(Duration) no yrs. no mos. 8 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cy nose

(Signed) Raymond C. Kramer, M. D.

Nov 7, 1924 (Address) Mt Winans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park	Nov 10, 1924
20-UNDERTAKER	ADDRESS
George J Smith	1532 Hollins st

Cor.—1-12-23--M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91752

CERTIFICATE OF DEATH.

188-903 91752

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph (Hosp ST., 7 WARD)

2-FULL NAME John G. Kohles

(a) RESIDENCE NO. 1 Mary Ave near Sprng ST., (Roslyn) WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) January 14 / 24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst Supt
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John G. Kohles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Christina Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Augusta Fuller (Aunt
(Address) 529 N Rose St

15 NOV 7 1924 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract. Skull - accidental
St. Paul's
(automobile accident)
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Culter, M. D. (Coroner.)

11-6, 1924 (Address) 538 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Cemetery — DATE OF BURIAL Nov 8 1924

20 UNDERTAKER Chas C. Guilliodson — ADDRESS 2334 Liberty St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

91753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001

D 91753

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N Streeper ST., 6 WARD)

2-FULL NAME George W Marshall

(a) RESIDENCE No. 413 N Streeper ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lavina Marshall Late

6 DATE OF BIRTH (month, day, and year) Sept 10-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & O R.R.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Justus Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda St Clair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Levina Green

(Address) 2309 Frankstown ave

15 FILED NOV 7 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1924, to Nov 4th 1924.

that I last saw him alive on Nov 4th 1924

and that death occurred, on the date stated above, at 1 10a m.

The CAUSE OF DEATH* was as follows:

Paralysis. Hemorrhage of Brain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hardening of Arteries & High Blood Pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Earle M. D.

Nov 6, 1924 (Address) 3902 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Nov 8 1924

20 UNDERTAKER Mrs C. Julia & Son

ADDRESS 2534 Jefferson

Spec.—8-24-14—M. & T.—2000 Bks.

D 91754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 91754

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2715 Riggs Ave ST.; 16 WARD)

2-FULL NAME Mrs. Wilhelmina Kelch

(Residence in Baltimore: No. 2715 Riggs ave St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb (Month) 11 (Day), 1838 (Year)

7-AGE, 86 yrs. 9 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, L. Shoemacher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henrietta Lochart

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ernest Hahn

(Address) 2715 Riggs Ave

15-

Filed ..... 19..

NOV 7 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. (Month) 6th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24th 1924, to Nov 6th 1924, that I saw her alive on Nov 6th 1924, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Senile Infirmities

..... (Duration) several years

CONTRIBUTORY (Secondary) Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. Vances Le Carpentier M. D.

Nov. 6th, 1924 (Address) 2401 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Nov. 8, 1924
20-UNDERTAKER	ADDRESS
William Cook	502 E North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 91755

CERTIFICATE OF DEATH.

188 B 91755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Gen'l Hosp. ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie C. Wheeler

(a) RESIDENCE No. 617 Rosedale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Wheeler

6 DATE OF BIRTH (month, day, and year) Feb-24-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ax Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jno. Priester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Germany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm R. Smith
(Address) 635 N. Carey St.

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ....yrs. mos 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

Nov. 6, 1924 (Address) 202 Courtland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov. 8 192

20 UNDERTAKER William Cook

ADDRESS 1628 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

D 91756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 91756

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Hope Street ST., 9 WARD)

2-FULL NAME James Henson Klarmann

(a) RESIDENCE NO. 1915 Hope Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank H Klarmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Prussia

12 MAIDEN NAME OF MOTHER Kathrin Mieder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant F H Klarman
(Address) 1915 Hope St

NOV 7 1924 Filed

HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Nov 7, 1924, that I last saw him alive on Nov 3, 1924, and that death occurred, on the date stated above, at 130 a m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac defect -

(duration) yrs. 3 mos yrs ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis? Clinical -

(Signed) John L. Feuby, M. D.

11/7, 1924 (Address) 3622 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Nov 8 1924

20 UNDERTAKER Wm Cook

ADDRESS 582 E North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D 91757

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 Hard Ford Ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Glenn

(a) Residence No. 2216 Hard Ford Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella H.

6-DATE OF BIRTH (month, day and year) May 12 1841

7-AGE. 83 yrs. 5 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto
(State or Country).

PARENTS.

10-NAME OF FATHER. Ralph Glenn

11-BIRTHPLACE OF FATHER (city or town) ..... Pa
(State or Country).

12-MAIDEN NAME OF MOTHER. Lydia Harrison

13-BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or Country).

14-

(Informant) Mrs Ella Glenn

(Address) 2216 Hard Ford Ave

15-

Filed ..... 1924 ROBERT W. KRAUTER,
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 6 — 1924 to Nov. 6 — 1924 that I last saw h.im alive on Nov. 6 — 1924 and that death occurred, on the date stated above, at 4-45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(Duration) — yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Edwin B. Fenby M. D

11/7/1924 (Address) 1223 N. Carolina St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Nov. 10 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Balto

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91758

CERTIFICATE OF DEATH.

REGISTERED NO. 16-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Homewood Hosp.

CITY OF BALTIMORE: (No. 2724 N. Charles ST., IV WARD)

2-FULL NAME Baby Raethmann

(a) RESIDENCE No. Wade Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 6th '24.

7 AGE: Years | Months | Days | If LESS than 1 day, ~~hrs~~ or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md. (Homewood Hospital)
(State or country)

PARENTS

10 NAME OF FATHER Walter Raethmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Julia Hensel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U. S. A.

14 Informant Mr. Walter Raethmann
(Address) Wade Ave. Catonsville

15 Filed NOV 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1924, to Nov 6, 1924, that I last saw h~~im~~ alive on Nov 6, 1924 and that death occurred, on the date stated above, at 11.20 p. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Malformation of membranes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/6/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert F. Steelman, M. D.

. 19 (Address) 6 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL Nov 8 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

REGISTERED NO. D 91759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dammann

(a) RESIDENCE No. 821 Park Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 009

(b) General nature of industry, business, or establishment in which employed (or employer) Freight Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER F.W. Dammann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary L. Macdonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Hospital Record Mercy Hospital

NOV 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/24. 19

17 I HEREBY CERTIFY, That I attended deceased from 10/20/24. 19 to 11/7/24. 19, that I last saw h~~e~~ alive on 11/6/24. 19 and that death occurred, on the date stated above, at 9.07 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Dld an operation precede death? Yes Date of 1922 Prostatectomy

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Golley M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 10 1924
20 UNDERTAKER Henry J. Jenkins & Son Co.	ADDRESS Cathedral & Mt. Colbert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91760

CERTIFICATE OF DEATH.

31 D 91760

REGISTERED NO.....

1-PLACE OF DEATH 1

CITY OF BALTIMORE: (No. 438 Furrow St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Dahling

(a) RESIDENCE NO. 438 Furrow St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Dahling

6 DATE OF BIRTH (month, day, and year) Jan 18 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
54	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Antonius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Fickelknid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Virginia Lucas

(Address) 438 Furrow

15 Filed NOV 7 1924 ROBERT R. KRAUTH, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Nov 6, 1924

that I last saw h-e alive on Nov 5, 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Nov 6 1924 (Address) 7687 Western Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov 10 1924

20 UNDERTAKER F. B. Wesfield — ADDRESS 2356 Fait Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91761

CERTIFICATE OF DEATH.

91-002 V

D 91761

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 541 E. Fayette ST.: 74 WARD)

2-FULL NAME Mary M. Snyder

(a) RESIDENCE. No. 541 E. Fayette ST., WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Snyder

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Casper Yeager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mc Keown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F. Snyder
(Address) 541 E. Fayette

15 Filed ..... 19 Robert P. Harris Registrar

NOV 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to Nov 6, 1924, that I last saw her alive on Nov 6, 1924, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with Hypertension

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Streett, M. D.

11/7, 1924 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	11/8/24

20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	318 Light

MARGIN RESERVED FOR BINDING

NOTICE TO PHYSICIANS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91762

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 W. 33 ST., 13 WARD)

2-FULL NAME Andrew J. Shipley

(a) RESIDENCE NO. 806 W. 33 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Martha Shipley

6 DATE OF BIRTH (month, day, and year) Apr 1 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Amos Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary land

12 MAIDEN NAME OF MOTHER Margaret Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Anna Shipley
(Address) 806 W 33 St

15 NOV 7 1924 Robert P. Harris...
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1924

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1924, to Nov 6, 1924, that I last saw him alive on Nov 6, 1924, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies, M. D.

19 24 (Address) 800 W 33 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park St Mary's Cemetery DATE OF BURIAL Nov 8 1924

20 UNDERTAKER D. S. Marshall ADDRESS 3539 Fall Rd

MARGIN RESERVED FOR BINDING

INK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—2500 Bks.

~~D 91763~~ 1375-824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D 91763

REGISTERED No.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Muse

(a) RESIDENCE No. 1343 Gilmore ST., St. WARD Bollers Whf. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Muse

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henery Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

NOV 7 Filed 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1924, to Nov. 6, 1924, that I last saw her alive on Nov. 6, 1924, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the spinal cord

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of the lungs

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Not demonstrated

(Signed) Trevor Owen, M. D.

Nov 7th 1924 (Address) Johns Hopkins Hospital Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bollers Whf. Va	Nov. 7 1924

20 UNDERTAKER Samuel H. Kusley ADDRESS 1118 N Middle

Spec.—1-10-21—M&T—1500 Blks.

(Harry Hall)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91764

90 D 91764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt. general Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Roslerve & Dulaney ST., 11 WARD)

2-FULL NAME Harry Hall

(a) RESIDENCE No. 951 madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1885

7 AGE 39 Years Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Thomas Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary E. Sway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Estelle Hall (Address) 951 Madison Ave

15 Robert P. Harrison, .19 Registrar

GV7 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/21 .1924. to nov. 6 .1924.

that I last saw him alive on nov. 6 .1924.

and that death occurred, on the date stated above, at 1:2..10 4 m.

The CAUSE OF DEATH* was as follows:

uraemia.

(1) mitral insufficiency.

(duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) yrs. mos. 7 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? clinical.

(Signed) Clement B Monroe, M. D.

.19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL Nov 9 1924

20 UNDERTAKER Edward Kinsley ADDRESS 878 W Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 91765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91765

CERTIFICATE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1903 Illamont St.

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Wm J. Louis -

(a) RESIDENCE NO. 1903 Illamont ST., 15 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 47 yrs. 4 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of [illegible] of Emma C Louis

6 DATE OF BIRTH (month, day, and year) July 2/1877

7 AGE: Years 47; Months 4; Days 4; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher. 813

(b) General nature of industry, business, or establishment in which employed (or employer): with Kruger Hardware Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jno Louis -

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs. Wm J. Louis - 1903 Illamont St.

15 [illegible] 19 ..... Registrar

NOV 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1924, to Nov 6th, 1924, that I last saw h[illegible] alive on Nov 6, 1924 and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH was as follows:

Bright's Kidney Disease
April 1924
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac, Dulcy 5
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of Employment

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Chas. E. Parker M. D.

, 19 (Address) 3123 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Nov. 10 1924

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1944 W. Northern

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

91766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-001 D 91766

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 806 N. Broadway ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael E. Lane

(a) RESIDENCE NO. 806 N. Broadway ST., ... WARD Boston Mass

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Lane

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Steam 186

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer Buerkel Co.

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER John Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Edward J. Lane, (Address) Dorchester Mass.

15 NOV 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/24 19

17 I HEREBY CERTIFY, That I attended deceased from 11/6/24, 19..., to 11/7/24, 19..., that I last saw him alive on 11/7/24, 1924, and that death occurred, on the date stated above, at 12 1/4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Leonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Pondyeri

(Signed) Alf S Sagl, M. D.

11/7. 1924 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass. DATE OF BURIAL: Nov. 7, 1924

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will please note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91767

CERTIFICATE OF DEATH.

+46

D 91767

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 4 WARD)

2-FULL NAME Mary Emma Guy.

(a) RESIDENCE NO. Mecca. Virginia ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Guy.

6 DATE OF BIRTH (month, day, and year) Feb 10, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John W. Landon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Norman T Guy (Address) Virginia

15 Filed 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 7

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Nov 7, 1924, that I last saw her alive on Nov 7, 1924, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid and Ovary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Lung)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 3, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. B. Whaley, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Onley Virginia	Nov 8 1924
20 UNDERTAKER George J Smith	ADDRESS 1552 Hollins St

KODAK S.A.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91768 ✓

D 91768

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 932 Woodyer ST. 16 WARD)

2-FULL NAME George W. Hall

(a) RESIDENCE NO. 932 Woodyer ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Hall

6 DATE OF BIRTH (month, day, and year) May 13-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER Thos. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Joseph C. Hall
(Address) 1727 Riggs Av.

15 Filed ..., 19 Robert P. Harrison, Registrar

CV1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5- 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1- , 1924 , to Nov. 4- , 1924 , that I last saw h~~e~~ alive on Nov. 4- , 1924 , and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 5- ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. C. McCarthut, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. — DATE OF BURIAL 11-8-1924

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91769

CERTIFICATE OF DEATH.

128 D 91769

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 Saratoga St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bacchus Walker

(a) Residence No. 721 Saratoga St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, ~~Married~~ Widowed, ~~Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), S. C.

PARENTS.

10-NAME OF FATHER James Walker

11-BIRTHPLACE OF FATHER (city or town) (State or Country) S. C.

12-MAIDEN NAME OF MOTHER Dill Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) S. C.

14- (Informant) Martha Walker

(Address) 721 Saratoga St

15- Filed NOV 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 5-24

I HEREBY CERTIFY, That I attended deceased from Oct 27 19 24 to Nov 5 19 24

that I last saw him alive on Nov 5 19 24

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows: Acute Nephritis

(over)

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) John A Stewart, M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL, 11-8- 24

20-UNDERTAKER David Eagan — ADDRESS 916 Ca ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91770

CERTIFICATE OF DEATH.

D 91770

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 Pierce St St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilson

(a) Residence No. 911 Pierce St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colord

5-Single, Married, Widowed, Divorced (write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1904

7-AGE. 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Va

PARENTS

10-NAME OF FATHER. Wm Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Va

12-MAIDEN NAME OF MOTHER. Lucie Seabrough

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14- (Informant) Lilly Wilson

(Address) 911 Pierce St

15- Filed NOV 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 6-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 — 1924 to Nov. 6 — 1924

that I last saw him alive on Nov. 6 — 1924

and that death occurred, on the date stated above, at 1045 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (Duration) 1 yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. G. W. Kennard M. D.

11-6 1924 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Auburn Cem	11-10-24
20-UNDERTAKER.	ADDRESS
David Easton	976 Ca nn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91771

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 Laurens ST. 16 WARD)

2-FULL NAME Monroe Key

(a) RESIDENCE No. 1437 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
(a) HUSBAND of Sadie Key
(b) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer Bernheimers

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Key

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ella Coats

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Sadie Key
(Address)

15 Filed NOV 7 1924 19 Robert P. Harrison, Registrar

NOV 7 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 19 24 to Nov 7 19 24
that I last saw him alive on Nov 6 19 24
and that death occurred, on the date stated above, at 2:40 P.M.

CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. J. Coleman M. D.

(Address) 703 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oldfield Frederick Co Md

DATE OF BURIAL 11-9-1924

20 UNDERTAKER Dent & Easton

ADDRESS 916 Pine

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 1 2001 ✓

D 91772

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 570 W. Preston St. ST., 17 WARD)

2-FULL NAME Martha O Weaver

(a) RESIDENCE No. 570 W. Preston St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Janice Ferguson 570 W. Preston St.

15 Filed NOV 7 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Nov. 9, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Burn — DATE OF BURIAL 11-8-24

20 UNDERTAKER Daniel Easton — ADDRESS 916 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91773 — 001 ✓ — 7 118 — D 91773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balt general Hosp.

CITY OF BALTIMORE: (No. Forrest Ave & Dukeland St. WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie may Stiffler.

(a) RESIDENCE NO. Parkton md. ST., WARD Parkton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward. F. Stiffler

6 DATE OF BIRTH (month, day, and year) ? 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkton md.

PARENTS

10 NAME OF FATHER mason Spicer

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Sarah Stiffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant West Balto General Hospital (Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov. 6. 1924

17

I HEREBY CERTIFY, That I attended deceased from nov. 2, 1924, to nov. 6, 1924,

that I last saw h e alive on nov. 6. 1924,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Strangulated femoral Hernia.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cordiac Dilatation

(duration) yrs. mos. 4-6 days

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of nov. 2. 192

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & operative

(Signed) Dr Hubert Wilkerson M. D.

19 (Address) West Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Cemtry — DATE OF BURIAL Nov 9 1924

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 125 E north ave

MARYLAND REGISTRATION BLANK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 7 - 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91774

CERTIFICATE OF DEATH.

D 91774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Hull St ST., 24 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Schwinger

(a) RESIDENCE NO 1205 Hull St ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman S-

6 DATE OF BIRTH (month, day, and year) — — 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 37
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Reis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred. Schwinger
(Address) 1205 Hull

Filed Jan 7 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) ... (Coroner), M. D.

Jan 7, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	1/8 1924
20 UNDERTAKER	ADDRESS
J. Kelly Sons	917 Light

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 91775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00

D 91775

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1903 Clifton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Hornick

(Residence in Baltimore: No. above ✓ Cor of Lower Pkgd St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, ..., 1883
(Month) (Day) (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cloak Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Leonard Hornick

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Rachael Connell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ed. Hornick

(Address) 1903 Clifton Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

OV8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1924, to Nov 5 1924, that I saw h ~~ee~~ alive on Nov 5 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

1a Influenza 5 Days

1b .....

1c .....

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Henry F. Connell M. D.

Nov 5, 1924 (Address) Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenwood Cem. DATE OF BURIAL, Nov 7, 1924

20-UNDERTAKER, M Kaufman & Son ADDRESS 1822 W North Ave

28.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MISTAKES OR ERRORS IN THIS CERTIFICATE, WHEN ORIGINALLY MADE, MAY BE CORRECTED BY THE REGISTRAR WITHIN ONE YEAR AFTER FILING, BUT NOT AFTERWARDS, EXCEPT BY ORDER OF THE COURT.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91776

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 102 W. Montgomery St., 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Taylor Grimes Noel

(a) Residence No. 102 W. Montgomery St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Noel

6-DATE OF BIRTH (month, day and year) Sept-23-1884

7-AGE. 40 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 103

(c) Name of employer.....

9-BIRTHPLACE (city or town) Northumberland Co.
(State or Country), Virginia

PARENTS

10-NAME OF FATHER, Alfred Fallin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Rice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant)..... Emma Noel

(Address)...1204 Riggs Ave

15-

Filed..... Robert P. Harrison,
Registrar.

NOV 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov-6-1924

17- I HEREBY CERTIFY, That I attended deceased from July-10, 1924 to Nov-6 1924

that I last saw her alive on Nov-5 1924

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus -

(Duration) yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? not Date of .....

Was there an autopsy? not

What test confirmed diagnosis? none

(Signed) Dan Duncan M. D

11/7, 1924 (Address) 1111 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Coan, Wyc. Va	11/8, 1924
20-UNDERTAKER, John H. Foadrin	ADDRESS 1027 Druid Hill Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91777

CERTIFICATE OF DEATH.

D 91777

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital St. 25 Ward)

Registered No.....

2-FULL NAME Jane Elizabeth Raab

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3901 Lloyd Ave St., 28 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 20 ds How long in U. S., if of foreign birth? 0 yrs. 0 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6-DATE OF BIRTH (month, day and year) Oct 18 1924

7-AGE, 0 yrs. 0 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Henry S. Raab

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Philadelphia Penna.

12-MAIDEN NAME OF MOTHER, Elizabeth M. Eastwood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Camden N. J.

14- (Informant) Henry S. Raab (Father)

(Address) 3901 Lloyd Ave. City.

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

NOV 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924, to Nov 7, 1924

that I last saw h.. alive on Nov 7, 1924

and that death occurred, on the date stated above, at 3.02 A.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John C. Baldwin M. D.

, 19 (Address) 1014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Yeadon-Penna. DATE OF BURIAL, Nov 8 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001 91778

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Flick

(a) Residence No. 2710 Orleans St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Agnes Flick

6-DATE OF BIRTH (month, day and year) 1859

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country),

PARENTS.

10-NAME OF FATHER, Carlos Flick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed NOV 8 - 1924, Robert F. [illegible], Clerk. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-7-24

17- I HEREBY CERTIFY, That I attended deceased from 1-2, 1924 to 11-7, 1924 that I last saw him alive on 11-6, 1924 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lot

(Signed) Claude C. Jones, M. D.

11-7, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park	Nov 8, 1924
20-UNDERTAKER, John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91779

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3225 Colgate St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Battee

(a) Residence No. 3225 Colgate St., 26 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 4 1924

7-AGE, ...yrs. ....mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Lewis Battee

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mabel Wehner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) William H Wehner

(Address) 226 N. Linwood Ave

15- Filed NOV 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1924 to Nov 7, 1924

that I last saw him alive on Nov 4, 1924

and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Premature foetus

6 1/2 months

.....(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....

(Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H B Tillow M. D.

11/7/24 19 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, Nov 8, 19 24

20-UNDERTAKER, Louis Heeman — ADDRESS 32 S Broadway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

(Batson)

D 91780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Homer J. Batson

(a) RESIDENCE NO 1822 W Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 15-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... brs. or ..... min.
	70		21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerdale Md

PARENTS

10 NAME OF FATHER Martin H. Batson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Dr Martin H. Batson
(Address) 1822 W. Baltimore St.

15 Filed NOV 8 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chest injuries due to being struck by A.B.R. Car

(Signed) W R Grinnalds, M. D.
(Coroner.)

11-8, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Nov 8 1924
20 UNDERTAKER Geo H Little	ADDRESS 710 Edmondson

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CLINICAL CONDITION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91781 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-901 91781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gregory (or Roberts)

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 OV8 - 1924 Robert F. Garrison, 19
Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 7 1924

17 I HEREBY CERTIFY, That I attended deceased from 11 - 2, 1924, to 11 - 7, 1924

that I last saw him alive on 11 - 7, 1924

and that death occurred, on the date stated above, at 8³⁰ a m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sol.

(Signed) Claude G. Bruce, M. D.

11-7, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL 11/10 1924

20 UNDERTAKER L. Frew McCully — ADDRESS 130 E. Front

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91782 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91782

CERTIFICATE OF DEATH.

90 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Spatz

(a) Residence No. 1426 Pennsylvania St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1846

7-AGE, 78 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address) .....

15- Filed ..... 19.. Registrar.

NOV 8 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-7-24

17- I HEREBY CERTIFY, That I attended deceased from 6-1, 1922, to 11-7, 1924, that I last saw him alive on 11-6, 1924, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis (Degenerative); Myocardial insufficiency

(Duration) yrs. 6 mos. (Hist.) ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Lab.

(Signed) Claude A. Lane, M. D.

11-7, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Dulls Cross Roads — DATE OF BURIAL, Nov 8, 1924

20-UNDERTAKER, James B Ayres — ADDRESS 1324 Eutaw Pl

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91783

CERTIFICATE OF DEATH.

41 D 91783

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 10 WARD)

2-FULL NAME William F George.

(a) RESIDENCE NO. 1222 E. Eager ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 (Single), Married, Widowed, or Divorced, (write the word)
Male	White	Single. -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30, 1922. -

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (no)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. -

PARENTS

10 NAME OF FATHER William F. George. -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mary Burkerdine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Mrs. Wm. F. George

(Address) 1222 E Eager St

15 Filed Nov 8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8. 1924 -

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924, to Nov. 8, 1924. -

that I last saw him alive on Nov. 8, 1924,

and that death occurred, on the date stated above, at 3:25 H m.

The CAUSE OF DEATH* was as follows:

Septicemia. -

of K. Corner Mastoiditis.

(duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) Acute epiphysitis. -

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? Home. -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cultures taken. -

(Signed) A. Austin Pearre, M. D.

11/8/24 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton, Md.	Nov. 9 1924
20 UNDERTAKER	ADDRESS
Henry Nash Son	1301 E Eager St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91784

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 91784

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1808 Hanover Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lawrence Hildebrandt

(a) Residence No. 1808 Hanover Ave St.,..... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 7th / 24

7-AGE, ...yrs. 6 mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Vincent Hildebrandt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rose Kozak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Vincent Hildebrandt

(Address) 1808 Hanover St

15- Filed ..... 192 ..... Registrar.

NOV 8 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). November 7/24

17- I HEREBY CERTIFY, That I attended deceased from October 17, 1924, to November 6, 1924, that I last saw h.... alive on November 6, 1924, and that death occurred, on the date stated above, at 9 A. ....m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia + Bronchitis

(Duration) .....yrs. 1 mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

Nov 7, 1924 (Address) 2008 E. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 8, 1924

20-UNDERTAKER, Frank Grace & Son — ADDRESS 1906 Gorsuch Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91785

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Patapsco ST., 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Schlimm

(a) RESIDENCE NO. 1440 Patapsco ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Schlimm

6 DATE OF BIRTH (month, day, and year) June 16 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Flamm

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dora Neidith

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Irwin H. Schlimm
(Address) 1440 Patapsco

15 Nov 8 - 1924 (19 ...) Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1924, to Nov. 5, 1924, that I last saw her alive on Nov 5, 1924, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Decompensated Mitral Regurgitation

(duration) ... yrs. mos 9 ds.

CONTRIBUTORY (Secondary) acute Dilatation of Heart 2 days

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos A Slevins, M. D.

11/7 1924 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Nov 8 1924

20 UNDERTAKER E.A. Krause & Son — ADDRESS 703 Hanover

8V8 - 1924

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 91786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91786

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 Maryland ave Brooklyn Md St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva V. Rottman

(a) Residence No. 400 Maryland ave Brooklyn md St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Rottman

6-DATE OF BIRTH (month, day and year) Feb-20-1883

7-AGE, 41 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS

10-NAME OF FATHER, Thomas Joyce

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER, Amanda Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-(Informant) Conrad Rottman

(Address) 400 Maryland ave

15-Filed NOV 8 1924 19?

Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov-6, 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 5 19 24 to Nov 6 19 24

that I last saw h alive on Nov 6 19 24

and that death occurred, on the date stated above, at 12:55 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Nephritis, Chronic -

(Duration) yrs. 5 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute cardiac dil.

Toxaemia (Duration) yrs. 2 mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George A. Bawden M. D

11/6 19 24 (Address) 1517 E. North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross R.C. Cem.	Nov. 10. 1924
20-UNDERTAKER.	ADDRESS
F.A. Kranse & Son	703 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91787 X 46 D 91787

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 811 West Mulberry St

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Precious Parker

(a) RESIDENCE NO. 811 W. Mulberry ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Parker

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Stripper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Antony Belle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rose Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Jos Parker
(Address) 656 N. Mulberry St

15 11-8-1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/24

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 1924 to Nov 6 1924.

that I last saw he alive on Nov 5 1924,

and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri (duration) yrs. 7 mos 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) 3 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 1656 N Franklin

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-8-24
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91788

CERTIFICATE OF DEATH.

D 91783

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp! St. 11th WARD)

2-FULL NAME Mr. Nisbet Turnbull

(a) RESIDENCE NO. 1600 Eutaw Place WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Alexander Turnbull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila, Pa.

12 MAIDEN NAME OF MOTHER Fannie Nesbet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Miss Fannie Turnbull

(Address) .....

15 Filed NOV 8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1924, to Nov. 7, 1924

that I last saw him alive on Nov. 7, 1924,

and that death occurred, on the date stated above, at 745. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism (1 min) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/3/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A Guilfillan M. D.

, 19 (Address) 11 W Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gouden Bark Cem

DATE OF BURIAL 11-10- 1924

20 UNDERTAKER Henry W Jenkins Undertaker

ADDRESS 2 Inward Mr Cullough

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Eks.

D 91789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91789

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 West Woodland Ave. Ward) 27

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sturgis Shumaman

(a) Residence No. 1 W Woodland Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced. (HUSBAND) of (WIFE) of Elizabeth Shumaman

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 64 yrs. - mos. - ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Butte

PARENTS

10-NAME OF FATHER. John Shumaman

11-BIRTHPLACE OF FATHER (City or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Margaret Sturgis

13-BIRTHPLACE OF MOTHER (City or town) (State or Country). South Carolina

14- (Informant) Elizabeth Shumaman

(Address) 1 Woodland Ave

15- Filed NOV 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 4/24

I HEREBY CERTIFY, That I attended deceased from Nov 2-15 1924, to ....., 19 24

that I last saw h. alive on Nov 4 19.....,

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Robert F. Hardesty M. D

, 19 (Address) Rogerstown & Belt Haywood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount	Nov 6, 1924
20-UNDERTAKER.	ADDRESS
H Kelly & Son	1520 North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91790

CERTIFICATE OF DEATH.

46 D 91790

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hos. ST., 17 WARD)

2-FULL NAME Margaret Peter Johnson

(a) RESIDENCE NO. 514 W. Biddle Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Johnson

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Bennett 206 Dolphin St

15 3V8 - 1924 . 19 Robert F. Harrison, Registrar

[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 — 7 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-31-, 1924, to 11—7—, 1924.

that I last saw her alive on 11—6—, 1924.

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri (cervix)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) W. Bayly Butler, M. D.

, 19 (Address) 2531 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov. 8 1924
20 UNDERTAKER Samuel S. Stanley	ADDRESS 78 N Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 91791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91791

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Shutter ST., 7 WARD)

2-FULL NAME Maggie Nesby

(a) RESIDENCE NO. 919 Shutter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Nesby

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 32 — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 0/0

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George Nesby

(Address): 919 Shutter st

15 Nov 8 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 5, 24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1924 to Nov. 5, 1924

that I last saw h[illegible] alive on Nov. 5, 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Gastric catarrh

(duration) yrs. 6½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno C. Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery — DATE OF BURIAL: Nov. 7 1924

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 1225 Ashland Av

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91792

CERTIFICATE OF DEATH.

1134 D 91792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Cypress ST., 25 WARD)

2-FULL NAME Joseph. Krysowaty

(a) RESIDENCE NO. 26 Cypress ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael. Krysowaty

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary. Jaszczenska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr Joseph. Krysowaty
(Address) 26 Cypress Street

15 Robert P. Harrison, Registrar

NOV 8 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 4, 1923, to Nov 7, 1924, that I last saw h[illegible] alive on Nov 7, 1924 and that death occurred, on the date stated above, at 5.50 p m.

The CAUSE OF DEATH* was as follows:

Illeo Colecystitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Valvular

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H Baum, M. D.

Nov 8, 1924 (Address) 80 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.Co.

DATE OF BURIAL 11-10 1924

20 UNDERTAKER John M Weber

ADDRESS 1503 Pine St

#16717

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

B 91793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 91793

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wyches

(a) RESIDENCE NO. 849 Lemon Alley ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept. 21-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leonard Wyches

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lillian Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 NOV 8 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1924, to Nov 7, 1924, that I last saw h.e alive on Nov 7, 1924, and that death occurred, on the date stated above, at 4.20 m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) & vomiting (duration) yrs. ..... mos ..... 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. ..... mos. ..... 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund H. Kemper, M. D.

1018 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bur Auburn Cem

DATE OF BURIAL 11/8 1924

20 UNDERTAKER Jas. W. Slimm

ADDRESS 1625 E. Monument

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91794

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 91794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Ehrig

(a) Residence No. 2136 Boyd St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1850

7-AGE,	If LESS than 1 day,
74 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Germany
(State or Country),

PARENTS.

10-NAME OF FATHER, Henry Helwig

11-BIRTHPLACE OF FATHER (city or town). Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). Germany
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 19.. Robert F. Garrison, Registrar.

NOV 8 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-7-24

17- I HEREBY CERTIFY, That I attended deceased from 9-10, 1924 to 11-7, 1924

that I last saw her alive on 11-7, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9-12-24

Was there an autopsy? Relatives refused Autopsy

What test confirmed diagnosis? Aut

(Signed) Claude G. Howe, M. D.

11-7, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lauden Park	Nov. 10, 1924

20-UNDERTAKER,	ADDRESS
Mr-Mrs N S Funk	1737 N Brad[illegible]

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 91795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91795

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1336 Washington Blvd St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wheeler.

(a) RESIDENCE No. 1336 Washington Blvd St.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Wheeler.

6 DATE OF BIRTH (month, day, and year) Feb 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary V. Malone (Address) 506 Peach Boulevard

15 NOV 8 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7. 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Nov. 7, 1924, that I last saw her alive on Nov 7. 1924, and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Uremic Coma. yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. O'Driscoll M. D.

, 19 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral cemetery	Nov 10th 1924
20 UNDERTAKER J. E. Moran	ADDRESS Baltimore

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91796 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 91796

CERTIFICATE OF DEATH. 124

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1825 Orleans ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Forbes

(a) RESIDENCE NO. 1825 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR ~~RACE~~	5 Single, Married, Widowed, or Divorced, (write the word)
F	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	yrs.	~~mos~~	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Marie Murray

(Address) 1825 Orleans st.

15 Filed NOV 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 30 -, 1924, to 11-7-, 1924,

that I last saw her alive on 11-6-, 1924,

and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

end points.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis end points

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas H Carmichael, M. D.

(Address) 611-11 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Md

DATE OF BURIAL NOV 9 1924

20 UNDERTAKER Robert J Williams

ADDRESS 1515 McCulloh st

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91797

CERTIFICATE OF DEATH.

100 B 91797

1-PLACE OF DEATH

City of BALTIMORE: (No. 937 Park ave St., 11 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nathaniel Darby

(a) Residence No. 937 Park ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 24. 1924

7-AGE. yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None.

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. Edward Darby

11-BIRTHPLACE OF FATHER (city or town) (State or Country), SC

12-MAIDEN NAME OF MOTHER. Fali Byrd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), SC

14- (Informant) Edward Darby

(Address) 937 Park ave

15- ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

NOV 9 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-8-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924 to Nov 8, 1924

that I last saw him alive on Nov 7 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Smuckler M. D.

11-8, 1924 (Address) 1176 Druidhill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-DATE OF BURIAL, CREMATION OR REMOVAL. Nov 8 1924

20-UNDERTAKER. Stephens & Hensley

ADDRESS 577 W Saratoga

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Genevieve D9/798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91798

CERTIFICATE OF DEATH.

60-62

REGISTERED NO. D 91798

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union memorial Hospital

CITY OF BALTIMORE: (No. 337 Calvert ST., 13 WARD)

2-FULL NAME genevieve Cohen

(a) RESIDENCE NO. 2038 Brookfield ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25. 1917

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Seven	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Hill cohen

11 BIRTHPLACE OF FATHER ~~(city or town)~~ Russia
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Marguestein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Sarah M Cohen
(Address) 2038 Brookfield ave

15 NOV 9 - 1924 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from oct 21, 1924, to nov 7, 1924, that I last saw her alive on nov 7, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) 2 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) myocardial failure

(duration) yrs. 0 mos. 1 hour

18 Where was disease contracted if not at place of death? Balto. md.

Did an operation precede death? yes Date of 11-7-24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) A. Gustav Scarr, M. D.

11/7 1924 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	11/9 1924
20 UNDERTAKER Sol Linsner & Bro	ADDRESS 1127 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91799.

175-84 D 91799

CERTIFICATE OF DEATH.

90 D 91799

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Landino

(a) RESIDENCE No. 246 S. Exeter ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Landino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetina Pasquale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant

(Address)

15 Filed NOV 8 1924 Registrar

JOHNS HOPKINS HOSPITAL ROBERT F. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7- 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1924, to Nov 7- 1924.

that I last saw him alive on Nov 7, 1924,

and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease
(Mitral + aortic insufficiency)

(duration) yrs. 5 mos ... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund A. Keiper, M. D.

11/7, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 10 1924

20 UNDERTAKER Kendall Dyffenbach ADDRESS 37 S ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

91800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91800

CERTIFICATE OF DEATH.

D. 91800

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 W. Glen Ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katharina W. Neuberger

(a) Residence No. 14 W. Glen Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Chas. Neuberger

6-DATE OF BIRTH (month, day and year) Nov. 18th 1864

7-AGE. 59 yrs. 11 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer). —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Henry Rechtern

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Veronica Ritzert

(Address) 14 Glen Ave Aberdeen

15- ROBERT R. KRAUTER, Registrar.

NOV 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7th 1924

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Nov. 7. 1924.

that I last saw her alive on Nov. 7. 1924

and that death occurred, on the date stated above, at 10 40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cassagne M. D

Nov. 8 1924 (Address) Glen Hills

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov. 14th, 1924
20-UNDERTAKER	ADDRESS
Lilly & Zeiler	4033 W. North Ave

NOTICE TO PHYSICIANS, NURSES, UNDERTAKERS AND OTHERS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

✓ 9.1801

D 91801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91801

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 E Chase St ST., 8 WARD)

2-FULL NAME Dougan A Gill

(a) RESIDENCE NO. 1705 E Chase St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah M. Gill

6 DATE OF BIRTH (month, day, and year) Nov 11 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Wm F Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria L. Popp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hannah M. Gill

(Address) 1705 E Chase St

15 NOV 9 - 1924 ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1923 to Nov. 7 1924

that I last saw him alive on Nov 5 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis of Hemic Cardiac Asthenia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Terry M. D.

11/8 1924 (Address) 6 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 10 1924

20 UNDERTAKER: Henry Lutz — ADDRESS: 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

SAFETY

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91802

CERTIFICATE OF DEATH.

D 91802

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Scott ST., 21 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate C. Halley

(a) RESIDENCE No. 1008 Scott ST., WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): aug 29: 1849

7 AGE — Years: 75 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: J. J. Calvert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Md

12 MAIDEN NAME OF MOTHER: Mary Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Laura Halley
(Address): 1008 Scott st

15 NOV 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1924, to Nov 7 1924, that I last saw h[illegible] alive on Nov 6th 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

La Grippe.

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Cystic Disease

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gruber, M. D.

11th, 1924 (Address) 517 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: 11-10 1924

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Baltimore st

Dr Tsabaud Poplar Grove at

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91803

CERTIFICATE OF DEATH.

D 91803

REGISTERED NO. 94803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S Loudon Ave ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Cook.

(a) RESIDENCE NO. 231 S Loudon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Cook

6 DATE OF BIRTH (month, day, and year): Nov 23 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Jno a.m.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Mamie Eloff

(Address) 231 S. Loudon Ave

15 NOV9 - 1924 ROBERT P. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924, to Nov 7, 1924,

that I last saw him alive on Nov 6, 1924

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Terminal

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senial Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no Objs. Exam.

What test confirmed diagnosis?

(Signed) John A Prahaud, M. D.

11/7/1924 (Address) 1219 Dolphin Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwarz Cemetery

DATE OF BURIAL: Nov 10 1924

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Fairmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

91804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91804

CERTIFICATE OF DEATH.

D 91804

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Riggs Ave. 16 WARD)

2-FULL NAME Norris L Milnor

(a) RESIDENCE No. 1900 N Riggs ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie Milnor

6 DATE OF BIRTH (month, day, and year): April 7, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	39	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Lafayette Mill Co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph K Milnor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emma Brichard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Sadie M Milnor
(Address): 1900 Riggs Ave

15 Filed NOV 9 1924 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

3 hrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary): no history (duration) yrs. mos. ds.

(Signed) J. J. Kennedy, M. D. (Coroner)

Nov. 8, 1924 (Address) 2 W Redwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 11/10 1924

20 UNDERTAKER: William Cook — ADDRESS: 522 E Nbd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91805 ✓ 91805

CERTIFICATE OF DEATH.

90 D 91805

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 583 Presstman ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora L. Berkeley

(Residence in Baltimore: No. 583 Presstman St.; 80 yrs., 5 mos. 6 ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 11 (Day), 1844 (Year)

7-AGE, 80 yrs. 5 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, not stated

13-BIRTHPLACE OF MOTHER (State or Country), not stated

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora L. Berkeley, daughter

(Address) 583 Presstman St.

15- NOV 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th (Month) (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 7 1917, to Nov 7 1924, that I saw h[illegible] alive on Nov 7 1924 and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Eshenaugh M. D.

Nov 8, 1924, (Address) 701 W. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov. 10th, 1924

20-UNDERTAKER J. B. M. Johnson

ADDRESS 1209 Dimd St. Balto.